NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Briefing paper: Antenatal care (update)

**Quality Standards Advisory Committee meeting**: 22 June 2022

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1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for antenatal care. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development sources are included to help the committee in considering potential statements and measures.

The paper uses the term 'women' throughout in line with the current NICE writing guide.

* 1. Development sources

The key development sources referenced in this briefing paper are:

[Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201) (2022).

[Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. NICE guideline CG110](https://www.nice.org.uk/Guidance/CG110) (2010).

1. Overview
   1. Focus of quality standard

The quality standard will cover the routine antenatal care pregnant women and their babies (and their partners and families, if appropriate) should receive during pregnancy up to 42 weeks.

It will update and replace the existing [NICE quality standard for antenatal care](https://www.nice.org.uk/guidance/qs22) (QS22).

* 1. Definition

Antenatal care refers to the routine care and check-ups that women get during their pregnancy. All pregnant women should be offered good antenatal care that is sensitive to their needs, identifies any problems early and helps them and their partners or families to feel confident and prepared for the birth of their baby.

Antenatal services are commissioned by clinical commissioning groups and integrated care systems. Providers are NHS hospital trusts and community providers. Commissioners are supported by local maternity systems whose responsibilities include developing a local vision for improved maternity services and outcomes which ensures that there is access to services for women and their babies, regardless of where they live. Their priorities include implementing [NHS England and Improvement’s (NHSE&I)’s 2016 National maternity review: Better births](https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/). Key components of better births are personalised and safer care, multi-professional working and working across boundaries. Reducing health inequalities is also a key priority.

* 1. Population

Approximately 700,000 women give birth in England and Wales each year. High quality maternity care reduces the likelihood of a poor outcome for the mother and baby.

The [MBRRACE-UK report: saving lives, improving mothers' care (2021)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reported that there are higher maternal mortality rates amongst older women, those aged under 20, women living in the most deprived areas and amongst women from particular ethnic minority groups. In particular, compared to white women, the maternal mortality rate was more than 4 times higher in women from Black ethnic backgrounds, 2 times higher for women from mixed ethnic backgrounds and almost twice as high for women from an Asian ethnic background.

The [MBRRACE-UK perinatal mortality surveillance report 2019](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlights the higher stillbirth rates for babies of Black and Asian ethnicity: rates are over twice as high as those for white babies and neonatal mortality rates 43% higher for babies of Black and Black British ethnicity. Stillbirth and neonatal mortality rates are both around 60% higher for babies of Asian and Asian British ethnicity compared with babies of white ethnicity. Babies born to mothers living in the most deprived areas are twice as likely to die stillborn and at a 73% excess risk of neonatal death compared to babies born in the least deprived areas.

* 1. Key policy initiatives

The national ambition is to halve rates (using 2010 rates as the baseline) of stillbirths, neonatal deaths and brain injuries during or soon after birth and maternal deaths by 2025 ([National maternity safety strategy: safer maternity care](https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps) – 2017 next steps report). A further aim is to reduce the national rate of preterm births from 8% to 6%. Although the rate of stillborn babies has fallen to its lowest rate in 20 years, it is still more than double the rate of nations with the lowest rates ([NHSE&I, Saving babies lives care bundle](https://www.england.nhs.uk/mat-transformation/saving-babies/) SBLCB – web page).

The saving babies live care bundle was updated in 2019 and brings together 5 interventions to help reduce stillbirth, based on the best available evidence and practice. Its implementation is incentivised as part of [NHS Resolution’s maternity incentive scheme](https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/). Directly relevant to antenatal care are reducing smoking in pregnancy, risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, raising awareness of reduced fetal movement and reducing preterm birth.

NHSE&I’s [2020 progress review of the implementation of the 2015 national maternity review Better Births](https://www.england.nhs.uk/publication/better-births-four-years-on-a-review-of-progress/) highlights that progress has been made towards meeting interim 2020 target for a 20% reduction in rates of stillbirth, perinatal mortality and maternal death to support the national safety ambition: the rate of reduction for stillbirths had been met and exceeded in 2018, although the rate of reduction would need to improve to meet the 2025 target. MBRRACE-UK data indicates that thesmaller reduction in neonatal mortality rates and maternal deaths suggests that the target will not be met for neonatal deaths.

An additional national ambition is set out in the [Smoke-free generation: tobacco control plan for England](https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england): to reduce the proportion of mothers who are smokers at the time they give birth to 6% by the end of 2022. Maternal smoking is strongly associated with increased risk of perinatal mortality and preterm birth. The number of mothers who smoke has declined over a long period of time and is 9.6% for 2020 to 2021. [NHS Digital’s statistics on NHS stop smoking services](https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england) (England) for April 2020 to March 2021 reports that 48% (8,678) of 18,087 pregnant women who set a quit date self-reported that they had quit. However, the rate of improvement needs to accelerate to reach the target.

NHSE&I’s [Equity and equality guidance for local maternity systems](https://www.england.nhs.uk/publication/equity-and-equality-guidance-for-local-maternity-systems/) (2021) sets out 5 key priorities. One is to restore services inclusively, including mitigating against digital exclusion, for example, when preparing personalised care and support plans, which are a priority for maternity services ([NHS long term plan (2019)](https://www.longtermplan.nhs.uk/) and [Better births](https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/) – the report of the 2015 national maternity review). Other aims include accelerating preventative programmes such as smoking cessation and diabetes prevention programmes to groups at the greatest risk of poor outcomes.

* 1. Current service delivery and management

Antenatal care can be delivered in a variety of settings, such as a woman’s home, a Children’s Centre, a GP surgery or a hospital and it can be initiated directly from a midwife (that is, not through a woman’s GP). Antenatal care services have also focused recently on delivering information and support to the whole family rather than solely to the woman, as highlighted by the [World Health Organisation’s declaration in 2016 that engaging fathers is a global priority.](https://www.familyinitiative.org.uk/fatherhood-programme#:~:text=In%202016%20the%20World%20Health%20Organisation%20declared%20that,health%20outcomes%20through%20the%20focused%20engagement%20of%20fathers.)

Antenatal appointments are offered throughout pregnancy to monitor the wellbeing of the woman and the baby, share information, discuss any concerns, plan for birth and prepare for the postnatal period. The routine content of each appointment depends on the phase of the pregnancy. The first antenatal care appointment involves an assessment of needs and risks to determine whether a woman needs additional care and support during the pregnancy.

The [Care Quality Commission’s (CQC’s) survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) (women who gave birth between 1 and 28 February 2021) and the [National Perinatal Epidemiology Unit’s (NPEU’s) You and your baby survey 2020](https://www.npeu.ox.ac.uk/maternity-surveys) explored health and experiences of maternity care during the COVID-19 pandemic. The NPEU ran 2 parallel surveys, one of which was the national maternity survey (NMS). Findings indicate that the pandemic had a significant impact on the way maternity care was delivered. NMS data showed that although 84% of women were satisfied with the overall care they received during pregnancy, changes to the delivery of care had a significant impact. Women who took part in the 2020 NMS had mostly pre-pandemic early antenatal care (autumn 2019) but their later antenatal care coincided with the first national lockdown (spring 2020); a parallel survey conducted on social media covered the births between March and August 2020. 44.5% and 49.4% of women responding to each survey did not attend antenatal classes because of cancellations due to COVID-19. Another source noted that carbon monoxide testing for example was suspended due to a shift to remote delivery ([The Healthcare Safety Investigation Branch national learning report on intrapartum stillbirth (2021](https://www.hsib.org.uk/investigations-and-reports/intrapartum-stillbirth-during-covid-19/)).

The [final Ockenden report: findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review) (SaTH), was published in March 2022. It aimed to address specific concerns at SaTH but also contains immediate and essential actions for all maternity services. These general recommendations include:

* Safe staffing (including a clear escalation policy and mitigation policy)
* Following national (NICE) guidance for managing women with diabetes and hypertension in pregnancy (and twin and multiple birth)
* Implementing [SBLCB version 2](https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/) to support managing women at risk of preterm birth, which includes counselling and the ‘most appropriate’ fetal monitoring.

1. Summary of suggestions
   1. Responses

In total 17 registered stakeholders responded to the 2-week engagement exercise.

* 14 stakeholders suggested areas
* 3 stakeholders had no comments

5 specialist committee members suggested areas

The responses have been summarised in table 1 for further consideration by the committee.

* 1. Priorities for committee discussion

Table 1 Summary of information available for suggested areas for improvement

| Suggested area for improvement | Stakeholder | In scope | Guideline recs | Current practice evidence | Existing QS statement | Priority to discuss? |
| --- | --- | --- | --- | --- | --- | --- |
| **Access to antenatal care and booking appointment**   * Access to antenatal care * Booking appointment | BTA, FI, NFASD, NCT, NHSE&I, RCM, SCMs  GPCPC, SCMs | Yes    Yes | Yes  Yes | Yes  Yes | Yes  Yes | **Yes**  **Yes** |
| **Risk assessment and referral**   * Risk assessment and referral – general and medical factors * Risk assessment and referral – social and lifestyle factors | BTA, FI, NHSE&I, RCM, SCMs  FI, NFASD, NMPA, RCM | Yes  Yes | Yes  Yes | Yes  Yes | Yes  Yes | **Yes**  **Yes** |
| **Continuity of carer** | NCT, RCM, SCMs | Yes | Yes | Yes | Yes | **Yes** |
| **Monitoring fetal growth and wellbeing**   * Risk assessment * Fetal movements after 24+0 weeks | SCMs  GPCPC | Yes  Yes | Yes  Yes | Yes  Yes | No  No | **Yes**  **Yes** |
| **Common problems during pregnancy and vaccination**   * Nausea, vomiting and hyperemesis gravidarum * Vaccination * Pelvic girdle pain | GPCPC, PSS  GPCPC, SCMs  POGP | Yes    Yes  Yes | Yes    Yes  No | Yes    Yes  No | No    Yes  No | **Yes**    **Yes**  **No** |
| **Information and support**   * Birth plan      * Breastfeeding and emotional attachment | BTA, NHSE&I, NMPA, RCM, SCMs  FI, NMPA, SCMs | Yes    Yes | Yes    Yes | Yes      Yes | Yes  No | **Yes**      **Yes** |
| **Additional areas**   * Diabetes in pregnancy * Equalities * Fetal anomaly screening * Information exchange * New guidance      * Language * Preeclampsia | RCN  RCN  DSA    GPCPC  BMUS, SCMs  BTA, SCoR  SCoR | No  Yes  Yes  Yes  Yes  Yes  No | Yes    N/A  Yes  Yes    N/A  N/A  No | N/A  N/A  No  Yes  N/A  N/A  N/A | In dev  N/A  Yes  Yes  N/A  N/A  N/A | **No**  **No**  **No**  **No**  **No**  **No**  **No** |
| Responded – no comment | BMFMS, RCGP, RCPCH | N/A | N/A | N/A | N/A | N/A |

Abbreviations

* BMFMS, British Maternal & Fetal Medicine Society
* BMUS, British Medical Ultrasound Society
* BTA, Birth Trauma Association
* DSA, The Down’s Syndrome Association
* FI, Fatherhood Institute
* GPCPC, GPs Championing Perinatal Care
* NCT, National Childbirth Trust
* NFASD, National FASD (FASD: Fetal Alcohol Syndrome Disorder)
* NHSE&I, NHS England and Improvement - Maternity transformation programme
* NMPA, National Maternity & Perinatal Audit
* POGP, Tutor Group of Pelvic Obstetric and Gynaecological Physiotherapy (UK-based professional network affiliated to the Chartered Society of Physiotherapy)
* PSS, Pregnancy Sickness Support
* RCGP, Royal College of General Practitioners
* RCM, Royal College of Midwives
* RCN, Royal College of Nursing
* RCPCH, Royal College of Paediatrics and Child Health
* SCM, Specialist Committee Member.
* SoR, The Society of Radiographers & The College of Radiographers

Full details of all the suggestions provided are given in appendix 2 for information.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Access to antenatal care and booking appointment

Access to antenatal care

Stakeholders felt that ensuring maternity services are visible in local communities to support the needs of vulnerable groups is a priority. Black, Asian and minority ethnic (BAME) women, migrant women and women who are refugees were highlighted as key groups to focus on.

They also highlighted that high-quality interpreting and translation services are essential to communicate effectively with women who are deaf and women for whom English is not their first language.

The need to support trans and non-binary people and women with fetal alcohol spectrum disorder and other neurodevelopmental conditions to access and participate in antenatal care services was highlighted.

Stakeholders felt that a shift to telephone and online consultations may pose a barrier to women making an appointment with their GP in order to access the booking appointment.

Stakeholders also had concerns around [how the ‘next steps’ for updated guidance on infection prevention and control measures announced by NHS England in June 2022](https://www.england.nhs.uk/publication/national-infection-prevention-and-control/) may affect access to antenatal care for women and their partners, particularly pregnant women and their partners (or family members) with comorbidities.

Stakeholders felt that it was important to provide a welcoming environment for partners.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.1.1 Ensure that antenatal care can be started in a variety of straightforward ways, depending on women's needs and circumstances, for example, by self-referral, referral by a GP, midwife or another healthcare professional, or through a school nurse, community centre or refugee hostel.

1.1.11 Ensure that reliable interpreting services are available when needed, including British Sign Language. Interpreters should be independent of the woman rather than using a family member or friend.

1.1.16 (extract): When planning and delivering antenatal services, ensure that the environment is welcoming for partners as well as pregnant women by, for example:

* displaying positive images of partner involvement (for example, on notice boards and in waiting areas)
* providing seating in consultation rooms for both the woman and her partner.
* considering providing opportunities for partners to attend appointments remotely as appropriate.

1.2.3 Be aware that, according to the [2020 MBRRACE-UK reports on maternal and perinatal mortality](https://www.npeu.ox.ac.uk/mbrrace-uk/reports), women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring and additional support. The reports showed that:

* compared with white women (8/100,000), the risk of maternal death during pregnancy and up to 6 weeks after birth is:
  + 4 times higher in black women (34/100,000)
  + 3 times higher in women with mixed ethnic background (25/100,000)
  + 2 times higher in Asian women (15/100,000; does not include Chinese women)
* compared with white babies (34/10,000), the stillbirth rate is
  + more than twice as high in black babies (74/10,000)
  + around 50% higher in Asian babies (53/10,000)
* women living in the most deprived areas (15/100,000) are more than 2.5 times more likely to die compared with women living in the least deprived areas (6/100,000)
* the stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for women living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000

[NICE's guideline on pregnancy and complex social factors (CG110](https://www.nice.org.uk/guidance/cg110)):

1.3.1 Healthcare professionals should help support these women's (pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English) uptake of antenatal care services by:

* using a variety of means to communicate with them
* telling women about antenatal care services and how to use them.
* undertake training in the specific needs of women in these groups.

1.3.2 Commissioners should monitor emergent local needs and plan and adjust services accordingly.

1.3.4 To allow sufficient time for interpretation, commissioners and those responsible for the organisation of local antenatal services should offer flexibility in the number and length of antenatal appointments when interpreting services are used, over and above the appointments outlined in national guidance.

1.3.5 Those responsible for the organisation of local antenatal services to provide information about pregnancy and antenatal services, including how to find and use antenatal services, in a variety of:

* formats, such as posters, notices, leaflets, photographs, drawings/diagrams, online video clips, audio clips and DVDs
* settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children centres, reception centres and hostels
* languages.

#### Current UK practice

122 Trusts (23,000 women) participated in the [CQC’s 2021 maternity survey](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) in February 2021:

* 50% of women said that they first spoke to a health professional when they were 7 to 12 weeks pregnant (53% in 2019).
* 61% said they first saw or spoke to a midwife and 34% saw their GP or family doctor when they thought they were pregnant (compared to 51% and 42% respectively in 2019).

A report from the [Royal College of Practitioners (RCGP, 2021) investigated the future role of remote consultations and patient ‘triage’](https://www.rcgp.org.uk/policy/general-practice-covid-19-recovery-consultations-patient-triage.aspx). The report highlights that before the first national lockdown, just over 70% of GP appointments were delivered face-to-face. Data collected for the [RCGP Research and Surveillance Centre Primary Care Workload Observatory](https://orchid.phc.ox.ac.uk/index.php/rcgprscworkloadobservatory/) shows that for:

* week 18 2022 (England, week beginning 2 May) - per 10,000 patients:
  + 216.3 face-to-face appointments
  + 239.7 telephone consultations
  + 9.4 e-consultations.
* week 18 2019 (week beginning 29 April) – per 10,000 patients:
  + 440.7 face-to-face appointments
  + 156.4 telephone appointments.

[MBRRACE-UK 2021, Saving lives, improving mothers’ care (UK and Ireland, confidential enquiries into maternal deaths, 2017 to 2019)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlighted that 16% (31 out of 191) of women who died between 2017 and 2019 received no antenatal care. In 17% of cases (13) this was identified as a direct (pregnancy-related) cause of death.

[A rapid evidence review (NHS Race and Health Observatory, 2022) of UK academic papers and grey literature (published 2011 to 2021)](https://www.nhsrho.org/publications/ethnic-inequalities-in-healthcare-a-rapid-evidence-review/) on ethnic inequalities in healthcare and within the NHS workforce reviewed evidence on maternal and neonatal health care, focusing on access and experiences. Studies identified a range of other factors:

* Lack of information in GP practices and community settings, which did not signal to women that it was important to register with a midwife.
* Language issues and lack of easy access to interpreter services.

Barriers identified to deter uptake among women who are migrants included:

* Presence of female genital mutilation and differences between the healthcare systems of their country of origin and the UK’s.
* Arrival in the UK late in pregnancy.
* Frequent relocations after arrival.
* Misgivings about the benefits of antenatal care.

Multiple [MBRRACE-UK saving lives, improving mothers’ care reports](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) have highlighted that family members should not be used as interpreters so that the woman and healthcare professional can communicate accurately and effectively. The [June 2020 to March 2021 rapid learning report](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) on maternal deaths related to and associated with COVID-19 reiterated this message in the context of remote consultations, highlighting how a lack of translation into a language a mother (and her partner) could fully understand may have affected a woman’s compliance with her treatment plan and her ability to obtain emergency assistance.

The Fatherhood Institute’s survey [How was it for you](http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/How-was-it-for-you-UK-results.pdf)? which formed part of the [2018 report Who’s the bloke in the room? Fathers during pregnancy and at the birth in the UK](http://www.fatherhoodinstitute.org/2022/contemporary-fathers-in-the-uk/) investigated fathers’ experiences of antenatal care. The findings for routine antenatal appointments highlight that 53.2% (670 out of 1,259 responses for the question) reported that they were ‘always’ made to feel welcome.

In 2022 the [LGBT Foundation](https://lgbt.foundation/news/revealed-improving-trans-and-non-binary-experiences-of-maternity-services-items-report/475) investigated trans and non-binary people’s experience of maternity services. 121 people responded to a survey between 9 November 2020 to 28 March 2021. The survey was based on questions used in the CQC maternity survey to enable comparison between the results. The number of responses to individual questions varied. The survey reported that:

* 30% of trans and non-binary people reported that theydid not access maternity care (NHS or private care) during pregnancy.
* 46% of trans and non-binary birth parents of colour reported that theydid not access maternity care (NHS or private care) during pregnancy.
* Nearly 30% reported being treated without respect and dignity, leading them to further avoid engaging with maternity services.

No current practice data on supporting women with FASD in maternity services was identified.

### Booking appointment

Stakeholders highlighted that arranging the booking appointment in time for it to be offered by 10+0 weeks of pregnancy is important so that key examinations and tests can be carried out in early pregnancy. Stakeholders highlighted the impact of continued adoption of remote delivery (highlighting a shift towards remote delivery in general practice) on access to the booking appointment: it was suggested that not all women may find telephone-based services an effective means of communication.

They also commented on aspects of delivery, including that face-to-face delivery is important, highlighting barriers posed by remote booking appointments.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201](https://www.nice.org.uk/Guidance/ng201)):

1.1.4 Offer a first antenatal (booking) appointment with a midwife to take place by 10+0 weeks of pregnancy.

#### Existing quality statements

[NICE’s quality standard on antenatal care (QS22):](https://www.nice.org.uk/Guidance/QS22)

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

#### Current UK practice

There is current practice data relating to the proportion of women who had a booking appointment within 10 weeks of pregnancy. [Experimental monthly data from the Maternity Services Data Set](https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics/february-2022-experimental-statistics) reports that of 54,760 bookings in February 2022, 57% were carried out during within the first 10 weeks of pregnancy, consistent with the proportion for the preceding 6 months. This is based on information from trusts who submitted booking data. (These statistics should be used with caution. Experimental statistics are new official statistics undergoing evaluation).

[MBRRACE-UK 2021, Saving lives, improving mothers’ care (UK and Ireland, confidential enquiries into maternal deaths, 2017 to 2019)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlighted that only 42% of the women who had received ‘any’ antenatal care were a) booked at 10 weeks and b) did not miss any antenatal appointments.

The NPEU’s [You and your baby 2020 survey](https://www.npeu.ox.ac.uk/maternity-surveys#:~:text=You%20and%20Your%20Baby%20Survey%202020%20You%20and,in%20England%20%28the%202020%20National%20Maternity%20Survey%20%28NMS%29%29.) investigated the impact of COVID-19 on maternity care and services and reported on the findings 4,611 women recruited from all births in England as part of the National Maternity Survey (NMS) 2020 and a parallel social media survey (1,622 responses). Where results are comparable from both surveys the NMS result is quoted. A number of questions investigated women’s preferences and experiences of how booking appointments – and routine antenatal appointments in general – were delivered. Most women (91.5% - 4,235 out of 4,559 responses) preferred face-to-face antenatal appointments.

Women’s birth partners were often unable to attend all appointments and scans. 80.7% stated their birth partners was unable to attend at least 1 antenatal appointment due to COVID-19.

### Resource impact

We do not expect this improvement area to have a significant impact on resources.

However, resource impact assessment for the NICE guideline 201 recognised that access to antenatal care and the time between women's first contact with a healthcare professional and subsequent step varies across the country. Therefore, addressing the variation might result in potential increase in capacity or costs to be assessed at a local level.

The recommendations from CG110 reflect current practice and are expected not to have a significant impact on resources.

### Issues for consideration

**For discussion:**

* What is the priority for improvement? Improving access to antenatal care or supporting access to the booking appointment in early pregnancy (by 10+0 weeks)?
* There is a NICE CCG indicator (CCG81) on Proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks+0 days.
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Risk assessment and referral

### Risk assessment and referral – general and medical factors

Stakeholders highlighted that a documented holistic risk assessment is a key component of each routine antenatal appointment.

They commented on the importance of discussing medical and obstetric history and the family history of both biological parents. Stakeholders however highlighted that fathers or partners are not being routinely actively involved by healthcare professionals even if they attend appointments. They felt that by actively involving the father the healthcare professional is more likely to obtainan accurate and complete history of both biological parents.

Stakeholders highlighted the need for early identification and onward referral for specialised management. A specific suggestion was improving recognition of symptoms of undiagnosed heart disease to enable timely referral to a multidisciplinary clinic. Assessment for risk of venous thromboembolism and testing for gestational diabetes following risk assessment were also highlighted as specific areas for improvement.

Women from BAME backgrounds were highlighted as important groups to focus on due to their greater risk of adverse outcomes. Stakeholders also commented that effective working relationships between health professionals is an important aspect of patient care and experience.

#### Selected recommendations – risk assessment (general)

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.1.14 A woman can be supported by a [partner](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#partner) during her pregnancy so healthcare professionals should:

* involve partners according to the woman's wishes and
* inform the woman that she is welcome to bring a partner to antenatal appointments and classes.

1.2.1 (extract) At the first antenatal (booking) appointment, ask the woman about:

* her medical history, obstetric history and family history (of both biological parents)
* her family and home situation, available support network and any health or other issues affecting her [partner](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#partner) or family members that may be significant for her health and wellbeing

1.2.10 At every antenatal appointment, carry out a risk assessment as follows:

* ask the woman about her general health and wellbeing
* ask the woman (and her partner, if present) if there are any concerns they would like to discuss
* provide a safe environment and opportunities for the woman to discuss topics such as concerns at home, domestic abuse, concerns about the birth (for example, if she previously had a traumatic birth) or mental health concerns
* review and reassess the plan of care for the pregnancy
* identify women who need additional care

1.2.11 At every antenatal contact, update the woman's antenatal records to include details of history, test results, examination findings, medicines and discussions.

1.2.12 At the first face-to-face antenatal appointment:

* offer to measure the woman's height and weight and calculate body mass index
* offer a blood test to check full blood count, blood group and rhesus D status.

#### Selected recommendations – medical factors

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.2.7: Refer the woman for a clinical assessment by a doctor to detect cardiac conditions if there is a concern based on the pregnant woman's personal or family history. See also the [section on heart disease in the NICE guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/chapter/Recommendations#heart-disease).

1.2.18 Assess the woman's risk factors for venous thromboembolism at the first antenatal (booking) appointment, and after any hospital admission or significant health event during pregnancy. Consider using guidance by an appropriate professional body, for example, the [Royal College of Obstetricians and Gynaecologists' guideline on reducing the risk of venous thromboembolism during pregnancy](https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg37a/).

1.2.20 For women at risk of venous thromboembolism, offer referral to an obstetrician for further management.

1.2.21 At the first antenatal (booking) appointment, assess the woman's risk factors for gestational diabetes in line with the [recommendations on gestational diabetes risk assessment in the NICE guideline on diabetes in pregnancy](https://www.nice.org.uk/guidance/ng3/chapter/Recommendations#gestational-diabetes).

1.2.22 If a woman is at risk of gestational diabetes, offer referral for an oral glucose tolerance test to take place between 24+0 weeks and 28+0 weeks [in line with the recommendations on gestational diabetes risk assessment](https://www.nice.org.uk/guidance/ng3/chapter/Recommendations#gestational-diabetes) and the [recommendations on gestational diabetes testing](https://www.nice.org.uk/guidance/ng3/chapter/1-Recommendations#testing) in the NICE guideline on diabetes in pregnancy.

[NICE’s guideline on diabetes in pregnancy (NG3](https://www.nice.org.uk/guidance/ng3)):

1.2.2 Assess the risk of gestational diabetes using risk factors in a healthy population. At the booking appointment, check for the following risk factors:

* BMI above 30 kg / m2
* previous macrosomic baby weighing 4.5 kg or more
* previous gestational diabetes
* family history of diabetes (first‑degree relative with diabetes
* family history of diabetes (first‑degree relative with diabetes.

Offer women with any of these risk factors testing for gestational diabetes.

#### Existing quality statements

[NICE’s quality standard on antenatal care (QS22](https://www.nice.org.uk/Guidance/QS22)):

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 8 Pregnant women at risk of venous thromboembolism at the booking appointment are referred to an obstetrician for further management.

#### Current UK practice – general

Based on 3,981 reviews of the death of every baby who died after 22 weeks’ gestation in the UK completed between March 2020 and February 2021, the [third annual report of the Perinatal Mortality Review Tool (2021)](http://www.npeu.ox.ac.uk/pmrt/reports), a collaboration between MBRRACE-UK and NPEU highlighted that delay in management of significant antenatal problems was relevant to 20% of deaths.

[The Fatherhood Institute’s survey How was it for you?](http://www.fatherhoodinstitute.org/2022/contemporary-fathers-in-the-uk/)  highlighted:

* 14.9% (14 responses) of fathers did not know that they were allowed to attend routine antenatal appointments.
* 22.4% (282 responses) reported that they were asked about their physical health.
* 18.0% (227) were asked about their mental health.
* 29.4% (370 out of 1,261 responses for the question) reported that they were ‘rarely’ or ‘never’ spoken to directly.
* 55.6% (700 out of 1,259 responses for the question) that they had ‘rarely’ or ‘never’ been addressed by name.
* 28.5% (358 out of 1,255 responses for the question) reported they were ‘always’ encouraged to ask questions.

[The final Ockenden report](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions) (2022) highlighted the importance of adetailed, thorough, comprehensive individualised and family-focused risk assessment as part of antenatal care so that care can be personalised and signposted to the most appropriate pathway. A lack of consistency, despite examples of good practice in referrals for additional care, when investigating additional care needed for vulnerable women, potentially exposing women and their babies to increased risk and potentially unnecessary harm. Formal risk assessment throughout pregnancy, at every antenatal contact, was identified as an essential action.

MBRRACE-UK’s [Saving lives: improving mother’s care (confidential enquiries into maternal deaths and morbidity)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlighted the importance of healthcare professionals working together effectively as a multidisciplinary team and this echoes findings of the earlier reports. The need for effective multidisciplinary working to support safe care was also emphasised in [the final Ockenden Report](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review).

#### Current UK practice – medical factors

MBRRACE-UK’s (2021) [Saving lives: improving mother’s care (confidential enquiries into maternal deaths and morbidity)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlighted that cardiac disease remains the largest single cause of indirect maternal death (12% of women who died between 6 weeks to 1 year after the end of pregnancy). The review also highlighted cases of maternal morbidity in older women who had assisted reproduction and are at higher risk of heart disease (and other comorbidities).

The report noted that 32 women died from VTE, with one exception, from pulmonary embolism. Obesity (see below), age and IVF were identified as VTE risk factors. The report highlighted that many had a risk score of 3, which should have prompted use of prophylactic low molecular weight heparin from 28 weeks. The report’s findings emphasised that VTE risk assessment tools for pregnant (and postpartum) women should be consistent with national guidance. [A review of strategies for maternal death from VTE based on clinical recommendations based on current literature (Rath W and Stelzl P, 2022)](https://doi.org/10.1515/jpm-2022-0069) highlighted that multiple MBRRACE-UK confidential enquiries (2021, 2018 and 2015) considered that 38% to 58% of deaths from VTE were potentially preventable. The 2016 MBRRACE-UK report highlighted that the most common reasons for substandard care are inaccurate assessment of risk factors, inappropriate prophylaxis, erroneous or misdiagnosis of pulmonary embolism and poor interdisciplinary cooperation.

Screening for management of gestational diabetes was identified in the [second annual report of the MBRRACE-UK – NPEU Perinatal Mortality Review Tool (2020)](http://www.npeu.ox.ac.uk/pmrt/reports) as an issue in 11% (164/1,500) of cases and that 17 issues (2% of 883) were relevant to the outcome between January 2018 and February 2019; between March 2019 and February 2020 it was relevant to 7% (246/3,693) of cases and 38 (2% of 1,871) were relevant to the outcome. [A national online survey of implementation of national guidelines for identifying gestational diabetes at maternity units (Bell et al, 2018, England)](https://www.sciencedirect.com/science/article/pii/S0168822718309896) assessed compliance with NICE guidelines for risk factor-based screening, BMI thresholds for offering oral glucose tolerance test (OGTT) and barriers to offering this test to women with BMI equal to or over 30 kg/m2. 113 out of an estimated possible 135 trusts responded to the survey, giving a response rate of 84%.

The survey highlighted that:

* 39% of the trusts were not compliant with all of [NICE's risk factor criteria](https://www.nice.org.uk/guidance/ng3)
* 25% of trusts did not offer OGTT to women with previous gestational diabetes
* 22% of trusts did not offer OGTT to women with a BMI of equal to or over 30 kg /m2 or offer it based on risk factors associated with ethnicity.
* Barriers to offering OGTT to women with a BMI equal to or over 30 kg/m2 were capacity, resource and funding given the high prevalence of maternal obesity

[The final Ockenden report](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions) recommended that trusts followed national guidance on managing women with diabetes in pregnancy as an essential action to support the delivery of complex antenatal care.

### Risk assessment and referral – social and lifestyle factors

Stakeholders were generally supportive of actively engaging fathers or partners in routine antenatal appointments, but they also had concerns around the reduction in opportunities for women to speak in private to the healthcare professional (away from their partner) especially if she is experiencing domestic violence or coercive behaviour.

Stakeholders highlighted that tailored discussions offer the opportunity to give information and support around smoking cessation, alcohol consumption during pregnancy, and healthy eating and physical activity. Stakeholders also commented that rates of smoking within different equality groups and that comorbidities (including diabetes and high blood pressure) in pregnant women who smoke would need to be considered when tailoring information and support. Stakeholders highlighted the association of higher rates of smoking in pregnancy with deprivation, and that a higher rate of white women smoked at delivery. Pregnant women in underserved groups who drank alcohol were highlighted as an important group.

Stakeholders suggested that aspects of the partner’s lifestyle (including smoking status, diet and exercise) should be discussed due to the impact on the woman and the baby.

Referral for lifestyle intervention services was identified as an important area. Stakeholders suggested that offering women and their partners referral to smoking cessation services was important as was signposting to support from voluntary organisations.

The update to [NICE’s quality standard on smoking: harm reduction (QS92)](https://www.nice.org.uk/guidance/qs92) is in development. Support for stopping smoking during pregnancy was raised as a quality improvement area but the committee felt that a statement in this area would have more impact in this quality standard.

#### Selected recommendations – social and lifestyle factors

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.1.6 If a woman books late in pregnancy, ask about the reasons for the late booking because it may reveal social, psychological or medical issues that need to be addressed.

1.2.4 If the woman or her partner smokes or has stopped smoking within the past 2 weeks, offer a referral to NHS Stop Smoking Services in line with [NICE’s guideline on Tobacco: preventing uptake, promoting quitting and treating dependence NG201.](https://www.nice.org.uk/guidance/ng209)

1.2.5 Ask the woman about domestic abuse in a kind, sensitive manner at the first antenatal (booking) appointment, or at the earliest opportunity when she is alone. Ensure that there is an opportunity to have a private, one‑to‑one discussion. Also see the [NICE guideline on domestic violence and abuse](https://www.nice.org.uk/guidance/ph50) and the section on pregnant women who experience domestic abuse in the [NICE guideline on pregnancy and complex social factors.](https://www.nice.org.uk/guidance/cg110/chapter/1-Guidance#pregnant-women-who-experience-domestic-abuse)

[NICE’s guideline on pregnancy and complex social factors (CG110):](https://www.nice.org.uk/guidance/cg110)

1.5.1 Women who experience domestic abuse should be supported in their use of antenatal care services by:

* training healthcare professionals in the identification and care of women who experience domestic abuse
* making available information and support tailored to women who experience or are suspected to be experiencing domestic abuse
* providing a more flexible series of appointments if needed
* addressing women's fears about the involvement of children's services by providing information tailored to their needs.

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.3.9 At the first antenatal (booking) appointment, and later if appropriate, discuss and give information about nutrition and diet, physical activity, smoking cessation and recreational drug use in a non-judgemental, compassionate and personalised way. See the [NICE guidelines on maternal and child nutrition](https://www.nice.org.uk/guidance/ph11), [vitamin D](https://www.nice.org.uk/guidance/ph56), [weight management before, during and after pregnancy](https://www.nice.org.uk/guidance/ph27), [smoking: stopping in pregnancy and after childbirth](https://www.nice.org.uk/guidance/ph26), and the [section on pregnant women who misuse substances (alcohol and/or drugs) in the NICE guideline on pregnancy and complex social factors.](https://www.nice.org.uk/guidance/cg110/chapter/1-Guidance#pregnant-women-who-misuse-substances-alcohol-andor-drugs)

1.3.10 At the first antenatal (booking) appointment, and later if appropriate, discuss alcohol consumption and follow [the UK Chief Medical Officers' (UKCMO) low-risk drinking guidelines](https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking). Explain that:

* there is no known safe level of alcohol consumption during pregnancy
* drinking alcohol during the pregnancy can lead to long-term harm to the baby
* the safest approach is to avoid alcohol altogether to minimise risks to the baby.

[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence (NG209)](https://www.nice.org.uk/guidance/ng209)

**Support to stop smoking in primary care and community settings**

1.13.1 For people who want to stop smoking:

* discuss with them how they can stop ([NCSCT programmes](http://www.ncsct.co.uk/pub_training.php) explain how to do this)
* provide stop-smoking interventions and advice; see the [section on stop-smoking interventions](https://www.nice.org.uk/guidance/ng209/chapter/recommendations-on-treating-tobacco-dependence#stop-smoking-interventions)
* if you are unable to provide stop-smoking interventions, refer them to local [stop-smoking support](https://www.nice.org.uk/guidance/ng209/chapter/terms-used-in-this-guideline#stop-smoking-support), if available
* if they opt out of a referral to stop-smoking support, refer them to a professional who can offer pharmacotherapy and [very brief advice](https://www.nice.org.uk/Glossary?letter=V).

**Information on stopping smoking for those using acute, maternity and mental health services**

1.14.1 (extract) Give people information about the smokefree policy before their appointment, procedure or hospital stay. This should cover:

* the short- and long-term health benefits of stopping smoking at any time; for example, stopping smoking at any time before surgery has no ill effects (although people may experience short-term withdrawal symptoms such as headaches or irritability from quitting), and people who stop in the 8 weeks before surgery can benefit significantly.
* the risks of secondhand smoke
* the types of support available to help them stop smoking or temporarily before, during or after an admission or appointment (see the [sections on behavioural support in acute and mental health services](https://www.nice.org.uk/guidance/ng209/chapter/recommendations-on-treating-tobacco-dependence#behavioural-support-in-acute-and-mental-health-services) and [supporting people who have to stop smoking temporarily)](https://www.nice.org.uk/guidance/ng209/chapter/recommendations-on-treating-tobacco-dependence#supporting-people-who-have-to-stop-smoking-temporarily)
* about the different [pharmacotherapies](https://www.nice.org.uk/guidance/ng209/chapter/terms-used-in-this-guideline#pharmacotherapies) that can help with stop smoking and [temporary abstinence](https://www.nice.org.uk/guidance/ng209/chapter/terms-used-in-this-guideline#temporary-abstinence), where to obtain them (including from GPs) and how to use them.

1.14.2 Before a planned or likely admission to an inpatient setting, work with the person to include how they will manage their smoking on admission or entry to the secondary care setting in their personal care plan.

1.14.4 Provide information and take the opportunity to provide advice to visitors about the benefits of stopping smoking and how to contact local stop-smoking support.

**Referring to behavioural support in acute, maternity and mental health services**

1.14.5 Offer and, if the person agrees, arrange for them to receive [behavioural support](https://www.nice.org.uk/guidance/ng209/chapter/terms-used-in-this-guideline#behavioural-support) to stop smoking during either their current outpatient visit or their inpatient stay.

1.14.6 For people using secondary care services in the community, staff trained to provide behavioural support to stop smoking should offer and provide support. Other staff should offer and, if accepted, arrange a referral to local stop-smoking support

**Supporting to stop smoking**

1.18.1 Provide routine carbon monoxide testing at all antenatal appointments to assess the pregnant woman's exposure to tobacco smoke.

1.18.2 Provide an opt-out referral to receive [stop-smoking support](https://www.nice.org.uk/guidance/ng209/chapter/terms-used-in-this-guideline#stop-smoking-support) for all pregnant women who:

* say they smoke or have stopped smoking in the past 2 weeks or
* have a carbon monoxide reading of 4 parts per million (ppm) or above or
* have previously been provided with an opt-out referral but have not yet engaged with stop-smoking support.

1.18.3 Explain to the woman:

* that it is normal practice to refer all pregnant women who smoke or have recently quit
* that the carbon monoxide test will allow her to see a physical measure of her smoking and exposure to other people's smoking
* what her carbon monoxide reading means, taking into consideration the time since she last smoked and the number of cigarettes smoked (and when) on the day of the test. [2021]

1.18.6 Record carbon monoxide level and any feedback given in the pregnant woman's antenatal records. If her antenatal records are not available locally, use local protocols to record this information.

**Identifying smoking among carers, family members and other household members**

1.11.8 (extract) At the earliest opportunity, ask if any of the following people smoke:

* partners of pregnant women.
* anyone else in the household. [2013]

1.11.10 If they do smoke:

* encourage them to stop if they are present, and refer them to a hospital or local stop-smoking support using local arrangements if they want to stop or cut down their smoking
* if they are not present, ask the person using services to suggest they contact stop-smoking support and provide contact details

1.11.11 During contact with partners, parents, other household members and carers of people using acute, maternity and mental health services:

* provide clear advice about the danger of smoking and secondhand smoke, including to pregnant women and babies – before and after birth
* recommend not smoking around the patient, pregnant woman, mother or baby (this includes not smoking in the house).

[NICE’s guideline on maternal and child nutrition (PH11):](https://www.nice.org.uk/guidance/ph11)

Recommendation 5 - Diet in pregnancy (extract):

* Early in pregnancy, discuss the woman's diet and eating habits and find out and address any concerns she may have about her diet.
* Provide information on the benefits of a healthy diet and practical advice on how to eat healthily throughout pregnancy. This should be tailored to the woman's circumstances. The advice should include: eat 5 portions of fruit and vegetables a day and 1 portion of oily fish (for example, mackerel, sardines, pilchards, herring, trout or salmon) a week.

Recommendation 6 - Obesity (extract)

Pregnant women who have a pre‑pregnancy body mass index (BMI) over 30, and those with a BMI over 30 who have a baby or who may become pregnant.

* Health professionals should refer pregnant women with a BMI over 30 to a dietitian for assessment and advice on healthy eating and exercise. Do not recommend weight‑loss during pregnancy.

[NICE’s guideline on weight management before, during and after pregnancy (PH27):](https://www.nice.org.uk/guidance/ph27)

Recommendation 2 – pregnant women

* At the earliest opportunity, for example, during a pregnant woman's first visit to a health professional, discuss her eating habits and how physically active she is. Find out if she has any concerns about diet and the amount of physical activity she does and try to address them.
* Offer practical and tailored information. This includes advice on how to use Healthy Start vouchers to increase the fruit and vegetable intake of those eligible for the Healthy Start scheme (women under 18 years and those who are receiving benefit payments).
* Advise that moderate-intensity physical activity will not harm her or her unborn child.
* Give specific and practical advice about being physically active during pregnancy. Advise women how to exercise safely following national guidelines on physical activity during pregnancy and during postpartum (see the [UK Chief Medical Officers' physical activity guidelines](https://www.gov.uk/government/collections/physical-activity-guidelines) for more information).
* Offer women with a BMI of 30 or more at the booking appointment a referral to a dietitian or appropriately trained health professional for assessment and personalised advice on healthy eating and how to be physically active. Encourage them to lose weight after pregnancy.

#### Existing quality statements – social and lifestyle factors

[NICE’s quality standard on domestic violence and abuse (QS116):](https://www.nice.org.uk/guidance/qs116)

Statement 1 People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.

[NICE’s quality standard on antenatal care (QS22):](https://www.nice.org.uk/guidance/qs22)

Statement 5 Pregnant women who smoke are referred for evidence-based stop-smoking support at the booking appointment.

[NICE’s quality standard on fetal alcohol spectrum disorder (QS204):](https://www.nice.org.uk/guidance/qs204)

Statement 1 Pregnant women are given advice throughout pregnancy not to drink alcohol.

Statement 2 Pregnant women are asked about their alcohol use throughout their pregnancy and this is recorded.

[NICE’s quality standard on nutrition: improving maternal and child nutrition (QS98):](https://www.nice.org.uk/guidance/qs98)

Statement 1 Pregnant women attending antenatal and health visitor appointments are given advice on how to eat healthily in pregnancy.

#### Current UK practice – social factors

The [MBRRACE-UK report: saving lives, improving mothers' care (2021)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reported that 33% (43) of women’s records lacked information on whether they were subject to domestic abuse before, during or after pregnancy. This is comparable to the 30% of records with information on whether the women who died stated whether they were subject to domestic abuse before or during pregnancy in the 2020 report. It was also noted in the 2020 report that although a substantial proportion of women are still not being asked, there has been some improvement since publication of the 2019 report. [MBRRACE-UK’s - NPEUs’ Perinatal mortality review tool’s 2020 annual report](https://www.npeu.ox.ac.uk/pmrt/reports) reported on 3,693 reviews from March 2019 to February 2020. The report highlighted that lack of appropriate screening for social issues or for domestic abuse at the booking appointment occurred in 22% of reviews (808/3,693) and this issue was relevant to the outcome in 3%. The 2021 annual report highlighted that questions about possible domestic abuse were not asked at the booking appointment due to remote delivery in 3% of reviews (3,981) completed between March 2020 and February 2021.

#### Current UK practice – smoking

The [NHS Long term plan](https://www.longtermplan.nhs.uk/) committed to supporting a smoke-free pregnancy pathway for all pregnant women by 2023/24. It is also supported by NHSE&I’s SBLCBv2, which states women should be offered testing for carbon monoxide exposure at booking, with appropriate referral for smoking cessation support. Data on the percentage of women who are current smokers at delivery is collected nationally. [Data published in March 2022 for December 2021](https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics/december-2021-experimental-statistics/analysis) shows that 12% of women with a recorded smoking status were smokers and 88% were non-smokers. 68% of women had a recorded smoking status at booking, which is an improvement compared to the previous year (32% for December 2020). Underlying data for December 2021 records that 4,335 of women were identified as a ‘smoker’ at booking, and 32,020 were recorded as a non-smoker or ex-smoker. Data was missing or outside reporting parameters in 17,405 of women**.** These are experimental data only and reporting for smoking status at booking is only available from May 2019. The data derived from SNOMED codes is still being developed and so data submitted may be limited depending on system supplier.

The [National Maternity and Perinatal Audit (NMPA) 2019 organisational survey report](https://maternityaudit.org.uk/Audit/Charting/Clinical) highlights that in January 2019, 72% of trusts and boards supported smoking cessation and remains similar to provision in 2017.

Current practice regarding barriers and facilitators of offering advice and referral smoking cessation services to support smoking cessation. [Naughton et al (published 2018) reviewed barriers and facilitators to smoking cessation in pregnancy and the postpartum period](https://doi.org/10.1111/bjhp.12314). Key findings include:

* Variation in commitment to addressing smoking during pregnancy among community midwives; some stated that they would only discuss it if it was relevant to the appointment. Most hospital midwives felt that routine discussion of smoking was a greater priority in the community setting.
* Midwives working in an area where an opt-out pathway was in place were more likely to discuss smoking. Some however had concerns about referring a women whom they felt lacked motivation to give at the point of referral.
* In some cases whether midwives perceived smoking as a priority was influenced by external factors such as whether NHS information was available, including for other health behaviours, or by priorities set externally, for example, on obesity.
* SSS participants commented that some referral information lacked detail and that referral rates were lower than expected in some areas where an opt-out referral applied.

Current practice highlights the role of the antenatal management of second-hand tobacco on outcomes. The [third annual report of the MBRRACE-UK –NPEU Perinatal Mortality Review Tool (2021)](http://www.npeu.ox.ac.uk/pmrt/reports) highlighted that lack of smoking assessment and management of exposure to tobacco smoke contributed to 8% of deaths, based on 3,981 reviews completed between March 2020 and February 2021. The 2020 report, based on 3,693 reviews (Match 2019 to February 2020), commented in more detail on cases where this was a factor: in 33% of deaths smoking issues were identified and by the far the most common was failure to perform carbon monoxide screening at the booking appointment. The second single most common issue relating to smoking was not offering referral to smoking cessation services for family members who live with the mother and who smoke: 5% (195). [The Fatherhood Institute’s survey How was it for you?](http://www.fatherhoodinstitute.org/2022/contemporary-fathers-in-the-uk/) reported that 51.5% (650 responses) of fathers were asked about their smoking at routine antenatal appointments.

#### Current UK practice – alcohol

[A mixed-methods design (survey, focus groups and interviews) to explore barriers and midwives’ beliefs about addressing alcohol during antenatal care with pregnant women was conducted by Smith et al](https://doi.org/10.1186/s12884-021-03583-1). 842 midwifes in the UK responded to the survey, 85% of whom were from England. The survey showed that 402 midwives (57%) in England were aware of the CMO guidelines. Of the 402 aware of the guidelines, 361 (90%) were aware that the content says to avoid alcohol completely during pregnancy. It also found that 97% of midwives in the UK ‘always’ or ‘usually’ advised women to abstain at the booking appointment, but this dropped to 38% at other appointments. Most midwives (70%) used no specific screening tool, many focused on ‘open conversations’ that were non-judgemental to encourage disclosure.

#### Current UK practice – weight management

An NMPA audit investigated aspects of obesity and support for weight management. The sprint audit ([NHS Maternity care for women with a Body Mass Index (BMI) of 30 or above](https://maternityaudit.org.uk/pages/sprintpub), England, Wales and Scotland) reviewed maternal and neonatal outcomes of pregnant women with BMI of 30 kg/m2 or above (data from over 1.38 million women) who gave birth between 1 April 2015 and 31 of March 2017, compared to those of women with BMI in the range 18.5 to 24.9. The report highlighted that:

* 21.8% (253,880) of birthing people had a BMI of 30 kg/m2 or above
* 16.9% (236, 419) of birthing people did not have a BMI (or height or weight) documented in their maternity records. This was more common in records from England and Wales than in Scotland.

The NMPA [2019 organisational survey highlights that in January 2019](https://maternityaudit.org.uk/Audit/Charting/Clinical) only 45% of trusts and boards supported weight management support, which is similar to the extent of provision for 2017. The proportion of freestanding midwifery units offering weight management support however decreased to 25%, from 30% in 2017.

[The Fatherhood Institute’s survey How was it for you?](http://www.fatherhoodinstitute.org/2022/contemporary-fathers-in-the-uk/)  reported that only 17.8% (225 responses) were asked about healthy eating and exercise.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
  + The content of the booking appointment or that 1 or more particular risk assessments is not being carried out?
  + Is the timing of risk assessments an issue? When are women first measured and weighed to calculate BMI?
  + In practice, how are women offered opportunities to talk to healthcare professionals without partners being present?
  + Support to stop smoking during pregnancy was identified as a priority during development of the update of [QS92](https://www.nice.org.uk/guidance/qs92) but the committee felt that a statement on this area would have more impact in this quality standard.
  + There are NICE CCG indicators on the proportion of women smoking at booking and delivery (CCG31 and CCG32).
  + NICE guidelines on [maternal and child nutrition and weight management are being updated and amalgamated](https://www.nice.org.uk/guidance/indevelopment/gid-ng10191) (expected to publish June 2023). An update may be required if a statement is progressed which refers to these guidelines.
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Which area or areas should be prioritised for inclusion in the quality standard and what is the specific action for quality improvement?
  1. Continuity of carer

There was a mixed response. Some stakeholders felt that continuity of carer should be included as a quality improvement area. Some however highlighted that pregnant women benefit from tailored care from specialist teams of midwives who specialise in caring for specific groups of women such as women with medically complex pregnancies, women with BAME backgrounds or women needing socially complex care.

Stakeholders commented that implementing continuity of midwifery carer (CoC) pathways aligns with national policy and system guidance, and supports improved outcomes such as reducing rates of preterm birth and loss.

Others felt that additional, robust evidence is needed before it is reintroduced, and that it should be suspended unless minimum staffing requirements could be achieved on all shifts.

It was suggested that delivering antenatal care to a group to support continuity of care more generally supports education and empowerment. Stakeholders also raised concerns that a lack of infection prevention and control measures may restrict access to opportunities for group discussion and peer support.

### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.1.12 Those responsible for planning and delivering antenatal services should aim to provide [continuity of carer.](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#continuity-of-carer)

1.3.4 (extract) When giving women (and their partners) information about antenatal care, use clear language, and tailor the timing, content and delivery of information to the needs and preferences of the woman and her stage of pregnancy. Information should support shared decision making between the woman and her healthcare team, and be:

* supplemented by group discussions (women only or women and partners)

[NICE’s guideline on pregnancy and complex social factors CG110](https://www.nice.org.uk/guidance/cg110):

1.2.4 Offer the woman a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances, and provide a direct-line telephone number for the named midwife or doctor.

1.4.4 Offer the young woman aged under 20 a named midwife, who should take responsibility for and provide the majority of her antenatal care, and provide a direct-line telephone number for the named midwife.

1.5.5 Offer the woman (section is on pregnant women who experience domestic abuse) a named midwife, who should take responsibility for and provide the majority of her antenatal care.

### Existing quality statements

[NICE’s quality standard on antenatal care (QS22):](https://www.nice.org.uk/Guidance/QS22)

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

### Current UK practice

Continuity of midwifery care throughout antenatal, intrapartum and postnatal care is a national policy priority with roll-out prioritised to tackle health inequalities. The 2021 GIRFT maternity and gynecology report ([available via the FutureNHS collaboration platform](https://future.nhs.uk/)) highlights the target of 35% by July 2021. [NHSE&I's (2021) Delivering midwifery continuity of carer at full scale](https://www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/) states that local maternity systems must ensure that at least 75% of women from BAME backgrounds and women living in the most deprived areas are on a CoC pathway by March 2024. Additional support is to be given to women living in the most deprived areas including that from maternity support workers who, for example, speak community languages as part of an enhanced CoC model. Significant funding has been allocated, and this will support training an extra 1,200 midwives and 100 obstetricians (from 2021/22, in response to the [first Ockenden report](https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2020/12/ockenden-report.pdf)), in addition to funding for enhanced CoC teams (initially, at 9 pilot sites, then to be rolled out nationally, pending evaluation, from 2023/24).

The [National Maternity Dashboard](https://app.powerbi.com/view?r=eyJrIjoiMzQ3YWY4MWQtZjEwNS00OGZhLWE3NzEtNzZmM2ViN2ViNWI0IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9&pageName=ReportSection3ed77151186ecd679338) contains 2 measures on CoC:

* The percentage of women with ‘ongoing’ CoC ongoing pathway.
* The percentage of women placed on CoC pathway by 28 weeks.

The second measure reflects the fact that women may be placed on a CoC pathway later than the time of the booking appointment. There is a routine antenatal care appointment at 28 weeks. The most recent national data identified is for February 2022: 22.6% (by 28 days) and 1.6% (ongoing).

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) reported that the pandemic and subsequent national restrictions have impacted on continuity of carer, with schemes closed in some areas. It reported that:

* 41% of women said they saw or spoke to the same midwife at every antenatal check-up (37% in 2019) .
* 46% of women said that the midwife or doctor they saw ‘always’ appeared to be aware of their medical history; 17% reported that they were not. Data from earlier years were not reported.
* 19% of women said that midwives who had cared for them during labour and birth had been involved in their antenatal care (up from 16% in 2019) .
* 11% of women said that at least one of the midwives who cared for them postnatally had also been involved in both their labour and antenatal care (up from 9% in 2019).

[The NPEU's You and your baby survey 2020](https://www.npeu.ox.ac.uk/maternity-surveys) highlighted that changes to appointments caused by COVID-19 resulted in the loss of continuity of care.

[The final Ockenden report](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review) recommended, as an essential action, that provision of continuity of care models are suspended at all trusts until – and unless – safe minimum staffing levels on each shift can be demonstrated. The report also highlighted that normally, it is not ideal for a labour ward coordinator to be caring for a woman in labour.

### Resource impact

We do not expect this quality standard to have a significant impact on resources.

For “Continuity of carer” (NICE CG110 recommendation 1.2.4) to offer the woman a named midwife or doctor who has specialised knowledge was considered to reinforce current practice but may have resource implications at a local level where a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances is currently unavailable.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
  + In light of the recommendation of the final report of the Ockenden review, should a statement on this area be progressed at this time?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Monitoring fetal growth and well being

### Risk assessment

Stakeholders highlighted the importance of recording, evaluating and exploring the woman’s full obstetric history at the booking appointment. Women who had a previous baby with fetal growth restriction or a preterm delivery, or a previous baby with fetal growth restriction and a preterm delivery were highlighted as important groups to focus on.

Exploring whether a woman was fully dilated at the time of emergency caesarean birth as a risk for preterm birth was highlighted as important so that additional monitoring in a preterm birth clinic can take place.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.2.1 (extract) At the first antenatal (booking) appointment, ask the woman about:

* her medical history, obstetric history and family history (of both biological parents).

1.2.29 Offer a risk assessment for fetal growth restriction at the first antenatal (booking) appointment, and again in the second trimester. Consider using guidance by an appropriate professional or national body, for example, the [Royal College of Obstetricians and Gynaecologists' guideline on the investigation and management of the small-for-gestational-age (SGA) fetus](https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/small-for-gestational-age-fetus-investigation-and-management-green-top-guideline-no-31/#:~:text=%20Small-for-Gestational-Age%20Fetus%2C%20Investigation%20and%20Management%20%28Green-top%20Guideline,the%20investigation%20and%20management%20of%20the%20SGA%20fetus.) or the [NHS saving babies' lives care bundle version 2](https://www.england.nhs.uk/mat-transformation/saving-babies/).

#### Current UK practice

The [third annual report of the MBRRACE-UK – NPEU Perinatal Mortality Review Tool (2021)](http://www.npeu.ox.ac.uk/pmrt/reports) highlighted that inadequate fetal growth surveillance was the single most common issue relevant to death, in common with the earlier 2 reports in this series (in 9% of 3,981 reviews on which the 2021 report is based).

187 NHS consultant units in the UK were surveyed on screening and management practice of the small for gestational age (SGA) fetus between 2016 and 2017 ([Sharp et al, 2018](https://doi.org/10.1016/j.ejogrb.2018.10.039)). The purpose was to determine current practice for the detection and subsequent management of the suspected SGA fetus, assessed against guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) ([Green-top guideline 31: small for gestational age fetus: investigation and management](https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/small-for-gestational-age-fetus-investigation-and-management-green-top-guideline-no-31/), published in 2013). The 3-round survey had a response rate of 65%. The study reported that 85% of units (103/121) carried out screening for SGA risk factors at booking as part of a clinical risk assessment. A limitation of this study is that it does not discuss use of the algorithm in the RCOG guideline in detail.

[An evaluation of the implementation of the saving babies’ live care bundle in early adopter NHS Trusts in England (Widdows et al 2021)](https://doi.org/10.1371/journal.pone.0250150) highlighted that detection of small for gestational age fetuses increased from 33.8% to 53.7% (using ‘before’ and ‘after’ data from 2013 and 2017) but did not discuss the role of a risk assessment based on obstetric history specifically. The study highlighted that use of ultrasound scanning, the principal screening method for SGA infants, increased by 24%. The study was based on a retrospective cohort study of 463,630 births in the 19 adopter trusts, supplemented by a case-note audit and surveys of service users.

[The final Ockenden final report noted](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review) (highlighting the saving babes’ lives care bundle version 2) that national guidance for monitoring of fetal growth has been conflicting and this has been a contentious issue across the UK over the last 20 years. There remains extensive regional variation in the adoption of guidance and practice. Improving practices for monitoring fetal wellbeing is one of the essential actions.

### Fetal movements after 24+0 weeks

Stakeholders felt that all healthcare professionals should enquire about and respond promptly to a woman’s concerns about reduced fetal movement beyond 24+0 weeks. Primary healthcare professionals were highlighted as a key group to focus on.

### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.2.34 Discuss the topic of babies' movements with the woman after 24+0 weeks, and:

* ask if she has any concerns about her baby's movements at each antenatal contact after 24+0 weeks
* advise her to contact maternity services at any time of day or night if she has any concerns about her baby's movements or she notices reduced fetal movements after 24+0 weeks
* assess the woman and baby if there are any concerns about the baby's movements.

1.3.13 After 24 weeks, discuss babies' movements.

### Current UK practice

The [third annual report of the MBRRACE-UK – NPEU Perinatal Mortality Review Tool (2021, based on 3,981 reviews)](http://www.npeu.ox.ac.uk/pmrt/reports)highlighted that inadequate investigation or management of reduced fetal movement, identified as relevant to the death in 8% of deaths and remains the second most common single issue identified as relevant to the death. Concerns about lack of response to reduce fetal movement had also been raised in the [MBRRACE-UK Perinatal confidential enquiries of 2015 and 2017](https://www.npeu.ox.ac.uk/mbrrace-uk/reports). The 2015 report had highlighted failure to respond to women’s attendance or repeat attendance.

[The evaluation of the implementation of the SBLCB (2016) in early adopter NHS Trusts in England (Widdows et al 2021)](https://doi.org/10.1371/journal.pone.0250150) highlighted that 74.4% of women were given a leaflet on reduced fetal movement following implementation of the SBLCB (version 1). Costing estimates indicate that midwives discussed the contents of the leaflet with women. Based on audit data,36.5% of women surveyed attended for reduced fetal movement. 64.9% had a scan after reporting any reduced fetal movement (17 trusts) and 97.3% had monitoringfor reduced fetal movement at every visit (17 trusts). The checklist in the SBLCB was used in 52.2% of cases (17 trusts).

[The final Ockenden final report noted](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review) included monitoring fetal wellbeing is one of the essential actions.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Should we focus on a specific audience or setting for a statement on reduced fetal movement, as suggested by stakeholders?
* NICE NG201 highlights the SBLCB as one of 2 examples of implementation tools. This resource, unlike the RCOG guideline (31), is supported by national policy.
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Common problems during pregnancy and vaccination

### Nausea, vomiting and hyperemesis gravidarum

Stakeholders highlighted that offering women a range of evidence-based non-pharmacological and pharmacological treatments is a quality improvement area.

They highlighted that women need prompt treatment due to its impact on their physical and mental health. They specifically suggested that cyclizine should not be prescribed.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201)

1.4.3 For pregnant women with mild‑to‑moderate nausea and vomiting who prefer a non-pharmacological option, suggest that they try ginger.

1.4.4 When considering pharmacological treatments for nausea and vomiting in pregnancy, discuss the advantages and disadvantages of different antiemetics with the woman. Take into account her preferences and her experience with treatments in previous pregnancies. See [table 1 on the advantages and disadvantages of different pharmacological treatments for nausea and vomiting in pregnancy](https://www.nice.org.uk/guidance/ng201/resources/table-1-advantages-and-disadvantages-of-different-pharmacological-treatments-for-nausea-and-vomiting-in-pregnancy-pdf-9204302125) to support [shared decision making](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#shared-decision-making). **(Appendix A, in which table 1 is presented in full).**

1.4.5 For pregnant women with nausea and vomiting who choose a pharmacological treatment, offer an antiemetic (see table 1).

1.4.6 For pregnant women with moderate‑to‑severe nausea and vomiting:

* consider intravenous fluids, ideally on an outpatient basis
* consider acupressure as an adjunct treatment.

1.4.7 Consider inpatient care if vomiting is severe and not responding to primary care or outpatient management. This will include women with hyperemesis gravidarum. Also see the [section on venous thromboembolism](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#venous-thromboembolism).

#### Current UK practice

A mixed-methods UK survey ([Nana et al, 2021](https://doi.org/10.1177%2F1753495X211040926)) of termination of wanted pregnancy and suicidal ideation in women with current or prior symptoms of hyper gravidarum used data from 5,071 responses submitted across 14 regions. The study collected data from women who self-reported a diagnosis of hyper gravidarum or severe sickness in pregnancy without confirmation. Findings highlighted that:

* 85.7% (4,172/4,863) of women took prescribed medication, and 41.2 % (2,004/4,863) of these woman had to actively request it.
* 69.0% (3,483/5,054) received rehydration therapy.
* 15.3% (732/4,796) and 24.1% (1,158/4,796) perceived their experience of primary care as extremely poor and poorrespectively.
* 9.9% (440/4,424) and 20.1% (887/4,424) perceived their experience of secondary care as extremely poor or poorrespectively.

Women who reported their experience of primary and secondary care to be extremely poorwere more likely to have not taken medication (for any reason, not specifically because it had not been prescribed) and not received rehydration treatment, compared to those reporting their experience to have been excellent.

Qualified GPs and GP trainees in Wales ([Nana et al, 2022)](https://doi.org/10.3399/BJGPO.2021.0119) were invited to respond to a survey to identify factors influencing prescribers’ confidence and knowledge around pharmacological therapy for hyperemesis gravidarum. 216 responses were received between January and March 2020. Findings highlighted that:

* 93% felt comfortable prescribing cyclizine, 57% prochlorperazine, 46% promethazine and 15% chlorpromazine.
* Additional qualifications, prior clinical experience and previous teaching relating to obstetrics and gynaecology were identified as factors that increased confidence levels.
* Responders who reported higher levels of confidence were significantly more likely to report that they recommended medications were safe to prescribe in pregnancy.

### Vaccination

Stakeholders highlighted that encouraging pregnant women to have vaccinations (influenza, pertussis and COVID-19) recommended for pregnant women is important as take-up is poor.

Stakeholders also suggested that pregnant women who need an MMR vaccination should be actively identified so that it can be offered to them postnatally.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201)](https://www.nice.org.uk/guidance/ng201/):

1.3.8 (extract) At the first antenatal (booking) appointment (and later if appropriate), discuss and give information on:

* immunisation for flu, pertussis (whooping cough) and other infections (for example, COVID‑19) during pregnancy, in line with the [NICE guideline on flu vaccination](https://www.nice.org.uk/guidance/ng103) and the [Public Health England Green Book on immunisation against infectious disease](https://www.gov.uk/government/publications/immunisation-against-infectious-disease-the-green-book-front-cover-and-contents-page)

[NICE’s guideline on vaccine uptake in the general population (NG218):](https://www.nice.org.uk/guidance/ng218)

1.2.9 (extract) Use every opportunity to identify people eligible for vaccination. This could include:

* when making contact with women who are trying to conceive or have a newly confirmed pregnancy, and at antenatal and postnatal reviews.

1.2.17 Midwives should offer vaccination to [pregnant women](https://www.nice.org.uk/guidance/ng218/chapter/recommendations#pregnant-women) during routine antenatal visits, as recommended by the [Green book](https://www.gov.uk/government/publications/pertussis-the-green-book-chapter-24) and the [NHS routine UK immunisation schedule](https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule). If the midwife cannot administer the vaccine, they should signpost women to vaccination services, drop-in clinics or their GP practice.

1.3.8 Practitioners working in maternity services and other healthcare practitioners who have contact with pregnant women should ensure that [pregnant women](https://www.nice.org.uk/guidance/ng218/chapter/recommendations#pregnant-women) are invited for vaccination or signposted to vaccination services or drop-in clinics.

1.3.15 At a pregnant woman's first appointment after the 20‑week scan, antenatal care providers should check whether they have been offered and accepted vaccination against pertussis in this pregnancy. If not, ensure they receive offers of vaccination or reminders (as relevant) at subsequent antenatal appointments or during any contact with their GP, midwife, health visitor or any other healthcare provider.

1.3.17 For [pregnant women](https://www.nice.org.uk/guidance/ng218/chapter/recommendations#pregnant-women) and [older people](https://www.nice.org.uk/guidance/ng218/chapter/recommendations#older-people) who do not respond to reminders, consider more direct contact such as a phone call. Explore with them the reasons for their lack of response and try to address any issues they raise.

#### Existing quality statements

[NICE’s quality standard on flu vaccination: increasing uptake (QS190)](https://www.nice.org.uk/guidance/qs190):

Statement 1 Providers use a range of different methods to invite people in eligible groups for flu vaccination.

Statement 2 People in eligible groups receive invitations for flu vaccination that include information about their situation or clinical risk

#### Current UK practice

The UK Health Security Agency provides data on uptake:

[Petrussis: Annual vaccine coverage (2020 to 2021):](https://www.gov.uk/government/publications/vaccination-against-pertussis-whooping-cough-for-pregnant-women/pertussis-whooping-cough-vaccination-programme-for-pregnant-women) 67.8%, which was lower than 2019, by 2.7%.

[Seasonal influenza uptake in GP patients: winter season 2020 to 2021](https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2020-to-2021) – pregnant women: 43.6%, compared to 43.7% in 2019 to 2020 (all pregnant women). Vaccine uptake was higher among women in a clinical ‘at risk’ group (57.7%), and was also slightly higher than in the 2019 to 2020 season (56.9%).

314 pregnant women and 204 healthcare professionals (of whom 75% were midwives and 18% obstetricians) in 4 NHS trusts within the south of England responded to a survey between July 2017 and January 2018 ([Wilcox et al, 2019).](https://journals.lww.com/pidj/fulltext/2019/06000/determinants_of_influenza_and_pertussis.17.aspx) The commonest reason for declining the pertussis or influenza vaccines was feared side effects to the fetus. White British women were significantly more accepting than non-white British women (96% compared to 83% respectively). Only 25% of healthcare professionals felt slightly or not at all confident discussing vaccinations. Obstetricians felt far more confident discussing the pertussis vaccination than midwives. Findings also highlighted that 53% of healthcare professionals felt that vaccines should be administered in general practice, and low support for alternative sites, including community midwifery (25%).

A further study ([Wilcox, Little and Jones, 2020](https://doi.org/10.3399/bjgp20X708113)) investigated current practice and attitudes of GPs towards antenatal vaccination and sought their views on the most optimal location for delivering it. 1,586 GPs in England responded to a multicentre online questionnaire between December 2018 and January 2019. Key findings include:

* GPs felt significantly less confident in their knowledge of the pertussis vaccine compared to the influenza vaccine (64% versus 80% respectively).
* Only 37% discussed vaccination with pregnant women regularly, although 80% felt that their recommendation would influence the woman’s decision making.
* GPs with greater confidence in their knowledge of pertussis and influenza vaccination, and who had qualified more than 2 years previously, discussed vaccination significantly more often, regardless of whether they saw pregnant women.
* Only 26% felt that antenatal vaccination should be primarily GP-based and suggested that midwives and or secondary care should take more responsibility for delivering antenatal vaccinations.

[The 2022 COVID-19 vaccine surveillance report for week 19](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1036047/Vaccine_surveillance_report_-_week_47.pdf) reported that COVID-19 vaccine coverage in women before they give birth increased as more women have become eligible for vaccination. Between January and August 2021, 355,299 women gave birth of whom 24,759 had received at least 1 dose of COVID-19 vaccine before delivery. For the 18,187 women where enough information was available to derive the trimester in which the vaccine was administered, 695 (3.8%) were immunised with their earliest vaccine dose in pregnancy in their first trimester, 4,487 (24.7%) were immunised in their second trimester and 13,005 (71.5%) in their third trimester.

Analysis of uptake data highlights that:

* women of black ethnicity and women living in the most deprived areas of England were least likely to have had 1 dose of COVID-19 vaccine before they gave birth.
* Coverage increased as levels of deprivation decreased. In the most deprived area (quintile 1) 7.8% of women who gave birth June to August 2021 were vaccinated; 26.5% were vaccinated in the least deprived quintile.

### Pelvic girdle pain

Stakeholders suggested that systematically identifying women at risk of severe pain or developing chronic pelvic girdle pain is a quality improvement area. They also highlighted that pelvic girdle pain due to pregnancy can have a considerable impact on function and quality of life, which needs greater recognition.

#### Selected recommendations

No relevant recommendations identified.

#### Current UK practice

Estimated prevalence: a systematic review of women’s experiences of pelvic girdle pain published in 2017 ([Mackenzie, Murray and Lusher](https://doi.org/10.1016/j.midw.2017.10.011)) highlighted that it can appear at any stage in pregnancy. It is estimated that between 14% and 22% of women experience it during pregnancy and that around 7% may experience the pain postnatally. No current practice data on the management of pelvic girdle pain was identified.

### Resource impact

Not expected to have a significant resource.

However, the resource impact for NG218 highlighted that some recommendations may represent a change to current local practice. Therefore, likely to have some resource implications at a local level. The changes were identified to be around improving audit and feedback, recording vaccination offers and administration, reminders and escalation of contact and vaccinating people not registered with a GP practice.

The statement also highlighted that uptake of vaccinations reduce the number and severity of outbreaks of diseases which are vaccinated against, improve record keeping and consistency of information held across different organisations and improve engagement with the healthcare system for people who are not registered with a GP practice.

### Issues for consideration

**For discussion:**

* What is the quality improvement area?
* What is the key action that will lead to improvement?
* NG201 does not provide comprehensive coverage of the management of nausea and vomiting in pregnancy, or hyperemesis gravidarum. The clinical knowledge summary on [nausea and vomiting in pregnancy](https://cks.nice.org.uk/topics/nausea-vomiting-in-pregnancy/management/management/) covers self-care, referral and unlike NG201, a sequencing of pharmacological treatment.
* Would a statement on vaccination achieve higher rates of uptake in this population? There are 2 statements on encouraging flu vaccination in eligible groups and this group includes pregnant women.
* No recommendations or current UK practice data to support a statement on pelvic girdle pain.
* Can we develop a specific, measurable statement?

**For decision:**

* Which area should be prioritised for inclusion in the quality standard?
  1. Information and support

### Birth plan

Stakeholders highlighted the importance of neutral, factual and evidence-based information about birth options. They emphasised that advice and information about maternity care should be personalised, with clarity around risks and benefits of different options for birth planning to support informed decision-making. They also highlighted that a birth plan should reflect assessment of a woman’s obstetric history and any current health conditions.

Stakeholders felt that information should be culturally accessible and, to enable effective planning, provided in a timely fashion. Checking that the woman (and her partner, if applicable) understands the information is critical. Stakeholders highlighted that COVID-19 restrictions resulted in a significant proportion of women giving birth without their birth partner being present.

Stakeholders felt that improving engagement with fathers in antenatal education and enabling them to be present at birth to support their partner is a quality improvement area.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201/)

1.3.14 Before 28 weeks, start talking with the woman about her birth preferences and the implications, benefits and risks of different options (see the [section on choosing planned place of birth in the NICE guideline on intrapartum care for healthy women and babies](https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth) and the [section on planning mode of birth in the NICE guideline on caesarean birth).](https://www.nice.org.uk/guidance/ng192/chapter/Recommendations#planning-mode-of-birth)

1.3.15 (extract) After 28 weeks, discuss and give information on:

* preparing for labour and birth, including information about coping in labour and creating a birth plan.

1.3.16 From 28 weeks onwards, as appropriate, continue the discussions and confirm the woman's birth preferences, discussing the implications, benefits and risks of all the options.

[NICE’s guideline on intrapartum care for healthy women and babies (CG190):](https://www.nice.org.uk/guidance/cg190/)

1.1.2 Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth:

* Advise low‑risk multiparous women that planning to give birth at home or in a midwifery‑led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
* Advise low‑risk multiparous women that planning to give birth at home or in a midwifery‑led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
* Advise low‑risk nulliparous women that planning to give birth in a midwifery‑led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

1.1.6 Commissioners and providers should ensure that all 4 birth settings are available to all women (in the local area or in a neighbouring area). [2014]

1.1.7 Give the woman the following information, including local statistics, about all local birth settings:

* Access to midwives, including:
  + the likelihood of being cared for in labour by a familiar midwife
  + the likelihood of receiving one‑to‑one care throughout labour (not necessarily being cared for by the same midwife for the whole of labour
* Access to medical staff (obstetric, anaesthetic and neonatal).
* Access to pain relief, including birthing pools, Entonox, other drugs and regional analgesia.
* The likelihood of being transferred to an obstetric unit (if this is not the woman's chosen place of birth), the reasons why this might happen and the time it may take. Refer to table 5 if no local data are available.

1.1.10 Use tables 6, 7, 8 and 9 as part of an assessment for a woman choosing her planned place of birth:

* [Table 6](https://www.nice.org.uk/guidance/cg190/chapter/recommendations#table-6-medical-conditions-indicating-increased-risk-suggesting-planned-birth-at-an-obstetric-unit) and [7](https://www.nice.org.uk/guidance/cg190/chapter/recommendations#table-7-other-factors-indicating-increased-risk-suggesting-planned-birth-at-an-obstetric-unit) show medical conditions or situations in which there is increased risk for the woman or baby during or shortly after labour, where care in an obstetric unit would be expected to reduce this risk.
* The factors listed in [table 8](https://www.nice.org.uk/guidance/cg190/chapter/recommendations#table-8-medical-conditions-indicating-individual-assessment-when-planning-place-of-birth) and [9](https://www.nice.org.uk/guidance/cg190/chapter/recommendations#table-9-other-factors-indicating-individual-assessment-when-planning-place-of-birth) are not reasons in themselves for advising birth within an obstetric unit, but indicate that further consideration of birth setting may be required.
* Discuss these risks and the additional care that can be provided in the obstetric unit with the woman so that she can make an informed choice about planned place of birth.

[NICE’s guideline on caesarean birth (NG192):](https://www.nice.org.uk/guidance/ng192/)

1.1.1 Offer all pregnant women information and support to enable them to make informed decisions about childbirth. Make sure that:

* the information is evidence based
* any information provided is accessible, ideally with a choice of formats to suit different women’s needs
* the language used in any information (written or oral) is respectful and suitable for the woman, taking into account any personal, cultural or religious factors that could form part of the woman's choices
* the women's preferences and concerns are central to the decision-making process

1.1.2 Discuss mode of birth with all pregnant women early in their pregnancy. Cover information such as:

* around 25% to 30% of women have a caesarean birth
* factors that mean women may need a caesarean birth (for example, increased maternal age and BMI)
* common indications for emergency caesarean birth include slow progression of labour or concern about fetal condition
* planned place of birth may affect the mode of birth (see [choosing planned place of birth in the NICE guideline on intrapartum care](https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#choosing-planned-place-of-birth))
* what the caesarean birth procedure involves
* how a caesarean birth may impact on the postnatal period (for example, need for pain relief)
* implications for future pregnancies and birth after caesarean birth or vaginal birth (for example, after a caesarean birth the chances of caesarean birth in a future pregnancy may be increased).

#### Existing quality statements

[NICE’s quality standard on intrapartum care (QS105)](https://www.nice.org.uk/guidance/qs105):

Statement 1 Women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes.

#### Current UK practice

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) reported that of the women surveyed:

* 71% were offered a choice of hospital in which to have their baby; 20% stated they were not offered any choice.
* 47% ‘definitely’ felt that they were given enough information from a midwife or doctor to help them decide where to have their baby, compared to 61% in 2019.
* 86% were ‘always’ spoken to in a way they could understand, compared to 89% in 2019.
* 77% felt they were ‘always’ involved in decisions about their antenatal care, compared to 82% in 2019.
* 73% were ‘definitely’ given enough time to ask questions about their pregnancy, compared to 79% in 2019.
* 79% reported their midwife always listened to them, compared to 83% in 2019.
* 37% were ‘definitely’ given enough information about coronavirus restrictions and any implications for their maternity care at the start of their care.
* 66% felt COVID-19 restricted the involvement of their partner or birth partner).

[NPEU's 2020 You and your baby survey](https://www.npeu.ox.ac.uk/maternity-surveys) reported that 53.6% of women **‘**always’felt involved in decisions about their care and 52**.**3% felt informed about how COVID-19 would affect their care. Findings also highlighted that women:

* felt less involved in decisions about their antenatal care compared to those who participated in pre-pandemic surveys.
* reported appointments lasting only a few minutes
* reported a lack of opportunity to ask questions.

A cross-sectional survey of all 122 UK maternity services reviewed, between October 2018 and February 2019, the extent to which local guidelines aligned with national guidelines using data from the Midwifery Study System (UKMidSS). The study ([Glenister, Burns and Row, 2020](https://doi.org/10.1371/journal.pone.0239311)) highlighted variation in admission criteria for midwife-led units which undermines evidence-based decision making when choosing place of birth. Comparison with [NICE’s guideline on intrapartum care: healthy women and babies (CG190)](https://www.nice.org.uk/guidance/cg190/) and comparable national guidelines for Scotland and Northern Ireland highlighted that:

* 7% of local guidelines aligned fully with national guidance.
* 53 separate admission criteria departed from national recommendations.
* Admission criteria that were more inclusive than national guidance tended to occur more frequently across guidelines than those that were more restrictive. The most frequently occurring more inclusive criteria included admission of women with parity of 4 or more, maternal age 35 to 40 years of age and BMI of 30 to 35kg/m2 and selective admission of women with a BMI 35kg/m2 to 40kg/m2.
* The most frequently occurring more restrictive criteria (around 30% of the guidelines) excluded women declining blood products, women having experienced female genital mutilation, with maternal age of under 16 years of age and inadequate antenatal care.

The authors highlighted that the more restrictive criteria (highlighted above) may disproportionately affect women from ethnic and religious minority backgrounds, women of young maternal age (under 16s) and women who have not received adequate (not defined) antenatal care.

[The final Ockenden report](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions) identified that women having ready access to accurate (current and evidence based, in line with national guidance) as an essential action to support women giving informed consent.

### Breastfeeding and emotional attachment

Stakeholders highlighted the importance of providing tailored information and support for breastfeeding during pregnancy. While recognising its importance to all pregnant women, it was suggested that support for breastfeeding needs to be targeted in groups where take-up is low.

Stakeholders suggested that engagement with partners is a quality improvement area. Enabling and encouraging father and partners’ involvement in antenatal education to support their role as a parent and promote emotional attachment was highlighted as a quality improvement area.

#### Selected recommendations

[NICE’s guideline on antenatal care (NG201):](https://www.nice.org.uk/guidance/ng201/)

1.3.8 (extract) At the first antenatal (booking) appointment (and later if appropriate), discuss and give information on:

* physical and emotional changes during the pregnancy
* relationship changes during the pregnancy
* how the woman and her partner can support each other
* resources and support for expectant and new parents
* how to get in touch with local or national peer support services.

1.3.11 (extract) Throughout the pregnancy, discuss and give information on:

* physical and emotional changes during the pregnancy
* relationship changes during the pregnancy
* how the woman and her partner can support each other
* resources and support for expectant and new parents
* how the parents can [bond](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#bonding-and-emotional-attachment) with their baby and the importance of [emotional attachment](https://www.nice.org.uk/guidance/ng201/chapter/recommendations#bonding-and-emotional-attachment) (also see the [section on promoting emotional attachment in the NICE guideline on postnatal care](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#promoting-emotional-attachment)).

1.3.20 Offer nulliparous women (and their partners) antenatal classes that include topics such as:

* preparing for labour and birth
* supporting each other throughout the pregnancy and after birth
* common events in labour and birth
* how to care for the baby
* how the parents can bond with their baby and the importance of emotional attachment (also see the section on promoting emotional attachment in the NICE guideline on postnatal care)
* planning and managing their baby's feeding (also see the section on planning and supporting babies' feeding in the NICE guideline on postnatal care).

1.3.21 Consider antenatal classes for multiparous women (and their partners) if they could benefit from attending (for example, if they have had a long gap between pregnancies, or have never attended antenatal classes before).

[NICE’s guideline on postnatal care (NG194):](https://www.nice.org.uk/guidance/ng194)

1.5.2 Before and after the birth, discuss breastfeeding and provide information and breastfeeding support (see the [section on supporting women to breastfeed](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#supporting-women-to-breastfeed)). Topics to discuss may include.

* nutritional benefits for the baby
* health benefits for both the baby and the woman
* how it can have benefits even if only done for a short time
* how it can soothe and comfort the baby

1.5.3 Give information about how the [partner](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#partner) can support the woman to breastfeed, including:

* the value of their involvement and support
* how they can comfort and bond with the baby.

1.5.9 Give information about how the partner can support the woman to breastfeed, including:

* face-to-face support
* written, digital or telephone information to supplement (but not replace) face-to-face support
* [continuity of carer](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#continuity-of-carer)
* information about what to do and who to contact if she needs additional support
* information for [partners](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#partner) about breastfeeding and how best to support breastfeeding women, taking into account the woman's preferences about the partner's involvement
* information about opportunities for peer support.

1.5.11 Be aware that younger women and women from a low income or disadvantaged background may need more support and encouragement to start and continue breastfeeding, and that continuity of carer is particularly important for these women.

1.5.12 Provide information, advice and reassurance about breastfeeding, so women (and their partners) know what to expect, and when and how to seek help. Topics to discuss include:

* how milk is produced, how much is produced in the early stages, and the supply-and-demand nature of breastfeeding
* [responsive breastfeeding](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#responsive-feeding)
* how often babies typically need to feed and for how long, taking into account individual variation
* feeding positions and how to help the baby attach to the breast
* signs of [effective feeding](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#effective-feed) so the woman knows her baby is getting enough milk (it is not possible to overfeed a breastfed baby; see also [recommendation 1.5.14](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#assessing-breastfeeding))
* expressing breast milk (by hand or with a breast pump) as part of breastfeeding and how it can be useful; safe storage and preparation of expressed breast milk; and the dangers of ['prop' feeding](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#prop-feeding)
* normal breast changes during pregnancy and after the birth
* pain when breastfeeding and when to seek help
* breastfeeding complications (for example, mastitis or breast abscess) and when to seek help
* strategies to manage fatigue when breastfeeding
* supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated (also see the [NICE guideline on faltering growth](https://www.nice.org.uk/guidance/ng75))
* how breastfeeding can affect the woman's body image and identity
* that the information given may change as the baby grows
* the possibility of relactation after a gap in breastfeeding
* safe medicine use when breastfeeding.

1.5.16 Before and after the birth, discuss formula feeding with parents who are considering or who need to formula feed, taking into account that babies may be partially formula fed alongside breastfeeding or expressed breast milk.

[NICE’s guideline on maternal and child nutrition (PH11):](https://www.nice.org.uk/guidance/ph11)

Breastfeeding (extract)

Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:

* education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).

#### Current UK practice – breast feeding

[NHS Digital’s NHS Maternity Statistics (2020-21, England)](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2020-21/births) show that 72.7% of babies had a first feed of breast milk.

[The Office for Health Improvement and Disparities experimental statistics 2020 to 2021](https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-annual-data-2020-to-2021) indicate that there was a breastfeeding rate of 47.6% at 6 to 8 weeks after birth. Breastfeeding prevalence ranged from 23.1 to 88.6% across 65 local authorities where suitable data was provided.

[A sprint audit (England, Scotland and Wales) conducted by the NMPA aimed to quantify inequalities associated with ethnic groups and social inequalities](https://maternityaudit.org.uk/pages/sprintpub). This was based on intrapartum interventions and specific maternal and perinatal outcomes for women giving birth in the devolved nations between 1 April 2015 and 31 March 2018, stratified by their ethic group and level of socio-economic deprivation.

The report highlighted that:

* Rates of babies receiving breast milk as their first feed were considerably lower (69.6%) for babies born to white women and to women living in the most deprived areas. The highest rates were for Black women (87.5%) and women in ‘other’ ethnic groups (85.3%).
* The rates for the most deprived group (using the Index of Multiple Deprivation, IMD) was 60.1%, and 83.1% for the least deprived group.
* Rates of feeding fell at discharge across all IMD groups.
* Teenage mothers under 20 years of age were less likely to initiate breastfeeding
* There is a significant decline in the rate of exclusive breastfeeding at 3 months across all ethnic groups and IMD quintiles ([Peregino et al](https://doi.org/10.1111%2Fmcn.12626), 2018).

The audit reported that IMD data was missing from 6% of women giving birth overall (highest in England, at 6%, and lowest for Wales, at 1%). Almost50% of the women were living in the 2 most deprived quintiles in each devolved nation. Ethnicity data was missing for 1 in 10 women in Great Britain (1 in 5 in Scotland).

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) reported that the proportion of women to say that during their pregnancy midwives ‘definitely’ provided relevant information about feeding their baby decreased from 57% in 2019 to 52% in 2021. The [2020 You and your baby 2020 survey](https://www.npeu.ox.ac.uk/maternity-surveys) (free text question) highlighted that some first-time mothers who had had their antenatal classes cancelled were disappointed that staff were not willing to educate them about breastfeeding and care of the baby.

#### Current UK practice – emotional attachment

A survey of 82 women pregnant with their first child from 3 regions (4 NHS trusts) in England ([Spiby, 2022 et al](https://doi.org/10.1016/j.midw.2022.103295)) highlighted that they felt that an important purpose of antenatal classes was to support their partner’s needs, emphasising the need to support the transition to fatherhood.

[The Fatherhood Institute’s survey How was it for you?](http://www.fatherhoodinstitute.org/2022/contemporary-fathers-in-the-uk/)  reported that:

* Only 23.9% (302 responses) of fathers felt that they and their pregnant partner were viewed as a couple at routine antenatal appointments.
* Only 35% (442 out of 1,262 responses for the question) reported that the father’s role had ‘often’ or ‘sometimes’ been discussed and 28.4% (359 out of 1,262 responses for the question) said it had ‘never’ been discussed.

### Issues for consideration

**For discussion:**

* What is the priority for improvement?
* If developed, a statement on the birth plan which uses recommendations from section 1.1.from NICE’s guideline on intrapartum care: healthy women and babies (CG190) may need to be updated after publication because the [guideline is being updated](https://www.nice.org.uk/guidance/indevelopment/gid-ng10174) (due to publish August 2023).
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 2 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| Diabetes in pregnancy | Yes | No | Yes | Yes |
| Equalities | Yes | No | N/A | N/A |
| Fetal anomaly screening | No | No | Yes | Yes |
| Information exchange | Yes | Yes | Yes | Yes |
| New guidance | No | No | No | Yes |
| Language | Yes | Yes | No | N/A |
| Preeclampsia | Yes | No | No | Yes |

### Diabetes in pregnancy

Stakeholders suggested that GPs should be responsible for HbA1c testing in women with gestational diabetes following birth as a quality improvement area.

This suggestion has not been progressed. At the prioritisation meeting for the update for [NICE’s quality standard on diabetes in pregnancy (QS109)](https://www.nice.org.uk/guidance/qs109), the quality standards advisory committee 2 (QSAC 2) progressed a statement on postnatal testing of women who had gestational diabetes at 6 to 13 weeks, an annual blood glucose test and referral to the National Diabetes Prevention Programme.

Stakeholders felt that the [updated quality standard on antenatal care (QS22)](https://www.nice.org.uk/guidance/qs22) should cover antipsychotic medicines (specifically, quetiapine or olanzapine) as a risk factor for gestational diabetes. This suggestion has not been progressed. NICE has developed a separate quality standard on [antenatal and postnatal mental health QS115](https://www.nice.org.uk/guidance/qs115).

### Equalities

Stakeholders suggested that health inequalities for at risk populations should be included in the quality standard’s equality impact assessment for women with gestational or pre-existing diabetes.

This suggestion has not been progressed. Additional care for women with diabetes in pregnancy is covered by [NICE’s quality standard on diabetes in pregnancy (QS109).](https://www.nice.org.uk/guidance/qs109)

### Fetal anomaly screening

Stakeholders suggested that improving pathways and support for women continuing with their pregnancy following results from fetal anomaly screening which indicates that their baby has a high chance of having a chromosomal condition is important. They connected this with the addition of non-invasive prenatal testing (NIPT) to the existing pathway for Down’s syndrome, Edwards’ syndrome and Patau’s syndrome in July 2021.

Although there is a statement (10) on screening in the current version of [NICE’s quality standard on antenatal care QS22](https://www.nice.org.uk/guidance/qs22), the approach to this area of care has changed since publication of the standard. Screening is the remit of the National Screening Committee.

### Information exchange

Stakeholders suggested sharing information with a woman’s GP should be routine (with the woman’s permission), even if there is no concern. Women with a prior mental health condition were highlighted as a key group.

This suggestion had not been progressed as the exchange of information between healthcare professionals is covered by NICE’s quality standard on patient experience in adult NHS services ([QS15, statement 3](https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-3-Information-exchange)).

### New guidance

Stakeholders felt that national guidance is needed on optimum use of ultrasound after 23 weeks gestation for growth scans. Advice on which maternal or fetal vessels to sample and when were flagged as specific concerns.

Stakeholders also highlighted studies on the risks of using e-cigarettes during pregnancy. They felt that using nicotine-filled cigarettes should be considered an equally significant risk factor for VTE as smoking.

These suggestions have not been progressed. The details will be passed to the Surveillance team.

### Language

Stakeholders expressed concerns around language used in the existing quality standard and about the [equality impact assessment](https://www.nice.org.uk/guidance/indevelopment/gid-qs10155/documents) published for the topic engagement exercise.

NICE’s style guide is being updated and is due to publish this month (June 2022). The update is expected to address these concerns. The quality standard, equality impact assessment and supporting documentation will be reviewed in light of these changes but will need to also be consistent with the style used for quality standards.

### Preeclampsia

A statement on preeclampsia was suggested by stakeholders. They commented that there is anecdotal evidence of the result of the pregnancy-associated plasma protein A (PAPP-A) test, which is obtained as part of screening for Down’s syndrome, Edwards syndrome and Patau’s syndrome, being used to screen for preeclampsia early in the first trimester, without the woman’s consent and outside of the scope of a screening programme.

This suggestion has not been progressed. Preeclampsia is covered by [NICE’s quality standard on hypertension in pregnancy](https://www.nice.org.uk/guidance/qs135).

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# Appendix 1: NICE’s guideline on antenatal care NG201: recommendation 1.4.5

Table 1 Advantages and disadvantages of different pharmacological treatments for nausea and vomiting in pregnancy

| **Medicine** | **Is this licensed for**  **nausea and vomiting in**  **pregnancy?** | **How effective is it likely**  **to be at treating nausea**  **and vomiting in**  **pregnancy?** | **Is it associated with an**  **increased chance of birth defects?** | **Other safety concerns**  **See the BNF and**  **manufacturers’**  **information for full**  **prescribing information** |
| --- | --- | --- | --- | --- |
| **Chlorpromazine** | No, but established  practice and used for many years.  Manufacturers advise it  should not be taken during pregnancy unless  considered essential. | No randomised controlled  trial evidence on nausea  and vomiting in pregnancy. | Available evidence does  not suggest an increased  chance of birth defects. | Use in the third trimester  may sometimes cause  nervous system side  effects in newborn babies  such as restlessness,  trembling, muscle stiffness or spasm (known as extrapyramidal side effects) or withdrawal symptoms. |
| **Cyclizine** | No, but established  practice and used for many years.  Manufacturers say taking it in pregnancy is not advised in pregnancy is not advised because it has not been proven to be safe. | No randomised controlled  trial evidence on cyclizine  alone for nausea and  vomiting in pregnancy.  Older, low quality evidence found a combination product of cyclizine with pyridoxine relieved nausea and vomiting (but this is not available in the UK). | Available evidence does  not suggest an increased  chance of birth defects. | Use towards the end of the third trimester may  sometimes cause side  effects in newborn babies  such as irritability and  jitteriness (known as  paradoxical excitability) and tremor. |
| **Doxylamine/pyridoxine**  **(combination drug)** | The only product  specifically licensed in the  UK for nausea and  vomiting in pregnancy. Not licensed for use by people aged under 18. | Some low or very low  quality evidence showed  symptom relief compared  with placebo.  Moderate or low quality  evidence from a small  study found it is less likely  to be effective than  ondansetron. | Available evidence does  not suggest an increased  chance of birth defects. | - |
| **Metoclopramide** | No, but established  practice as second-line  treatment for nausea and  vomiting in pregnancy.  Manufacturers say that it  can be taken during  pregnancy if necessary | High quality evidence found benefits on overall  symptom relief, nausea  intensity and vomiting  intensity compared with  placebo. | Available evidence does  not suggest an increased  chance of birth defects. | Not recommended for more than 5 days’ use or for people aged 18 or younger (except for specific conditions not related to nausea and vomiting in pregnancy) because of the risk of nervous system side  effects in the woman.  These include restlessness, trembling,  muscle stiffness or spasm  (known as extrapyramidal  side effects).  Use towards the end of the third trimester may sometimes cause  extrapyramidal side effects in newborn babies. |
| **Ondansetron** | No, but established  practice as treatment for  severe nausea and  vomiting in pregnancy.  Manufacturers advise it  should not be taken during the first trimester. | Moderate or low quality  evidence from a small  study found it is more likely to be effective than  doxylamine/pyridoxine  combination. | Increased chance of the  baby being born with a cleft lip or cleft palate. This is an increase of 3 extra cases per 10,000 from 11 in 10,000 to 14 in 10,000, so with ondansetron 9,986 out  of 10,000 babies would not have this.  Some evidence suggests  ondansetron may cause  heart problems in babies  but other evidence does  not support this. | - |
| **Prochlorperazine** | No, but established  practice and used for many years.  Manufacturers advise it  should not be taken during pregnancy unless  considered essential. The  manufacturers of the  Buccastem M brand say it  should not be taken in  pregnancy at all. | No randomised controlled  trial evidence on nausea  and vomiting in pregnancy. | Available evidence does  not suggest an increased  chance of birth defects. | Use in the third trimester  may sometimes cause  nervous system side  effects in newborn babies  such as restlessness,  trembling, muscle stiffness or spasm (known as extrapyramidal side effects) or withdrawal symptoms. |
| **Promethazine** | No, but established  practice and used for many years.  Manufacturers advise it  should not be taken during pregnancy unless  considered essential. | Limited, moderate quality  evidence found similar  benefits on vomiting  frequency to a combination product of metoclopramide  with pyridoxine (not  available in the UK). | Available evidence does  not suggest an increased  chance of birth defects. | Use towards the end of the third trimester may  sometimes cause side  effects in newborn babies  such as irritability and  jitteriness (known as  paradoxical excitability) and tremor. |

Information in this table is based on [NICE’s guideline on antenatal care (NG201): evidence review R: nausea and vomiting in pregnancy](https://www.nice.org.uk/Guidance/NG202/evidence), [UK Teratology Information Service](http://www.uktis.org/) monographs, the BNF and manufacturers’ summaries of product characteristics (SPCs). See the BNF and SPCs for other possible side effects, cautions, situations when the medicine might be harmful (contraindications), and potential interactions with other medicines.

Note that there is a background rate of birth defects, miscarriage and stillbirth even when no medicines are taken in pregnancy.

Quality of evidence (based on grading of recommendations, assessment, development and evaluations [GRADE]):

* **High**: Further research is very unlikely to change the level of confidence in the estimate of effect.
* **Moderate**: Further research is likely to have an important impact on the level of confidence in the estimate of effect and may
* change the estimate.
* **Low**: Further research is very likely to have an important impact on the level of confidence in the estimate of effect and is likely
* to change the estimate.
* **Very low**: The estimate of effect is very uncertain.

# Appendix 2: Suggestions from registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- |
| 1 | Birth Trauma Association | **Access to antenatal care and booking appointment** | 3) Make sure that adequate interpreter and translation facilities are provided for all women for whom English is not a first language, including deaf women. |  |
| 2 | Fatherhood Institute | **Access to antenatal care and booking appointment**  A welcoming environment | Create a welcoming environment for partners, for example, seating in consultation rooms and positive images in waiting areas. [NICE antenatal care guideline 1.1.16] |  |
| 3 | GPs Championing Perinatal care | **Access to antenatal care and booking appointment**  The booking appointment should be conducted face-to-face with a woman | Provision of community midwifery services was significantly disrupted during the first 2 years of the COVID-19 pandemic with a significant shift to remote consulting. The return to face to face midwifery booking appointments has been variable. Now that the evidence and understanding around COVID-19 pathogenicity is better understood, face to face booking appointments should, on the whole, be standard. | NG201 provides a comprehensive list of topics to be covered in the booking appointment, including physical checks and investigations that mean a face-to-face appointment with a midwife is an effective way to provide this. |
| 4 | National Childbirth Trust | **Access to antenatal care and booking appointment** | Recent research by the LGBT Foundation found that 30% of trans and non-binary people in their sample did not access maternity care during pregnancy. This rose to 46% of trans and non-binary birth parents of colour. Nearly 30% of respondents reported not being treated with respected and dignity, which fed into a desire to avoid maternity services. For many, they experienced both transphobia and racism.  As such, in addition to linking to the NICE guidance on pregnancy and complex social factors [CG110], the Equality and diversity considerations should include reference to the Equality Act 2010 and the need to design and deliver services in a way that are accessible to all people who have protected characteristics. | LGBT Foundation (2022). Trans + Non-binary Experiences of Maternity Services. London: LGBT Foundation. Available from: [Trans Pregnancy Survey (dxfy8lrzbpywr.cloudfront.net)](https://dxfy8lrzbpywr.cloudfront.net/Files/97ecdaea-833d-4ea5-a891-c59f0ea429fb/ITEMS%2520report%2520final.pdf) [Accessed 09/05/22]. |
| **5** | **National FASD** | **Access to antenatal care and booking appointment**  **Equality and diversity** | **Pregnant mothers with FASD (or other neurodevelopmental conditions) 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.** |  |
| 6 | NHS England & Improvement | **Access to antenatal care and booking appointment** | Ensuring that reliable interpreting services are available when needed, including British Sign Language. Interpreters should be independent of the woman rather than using a family member or friend. 1.1.11 | Assist with national priorities and work going on around equity/equality and safety/Ockenden response |
| 7 | Royal College of Midwives | **Access to antenatal care and booking appointment**  Improving access to and experience of high-quality antenatal care for vulnerablegroups likeBlack, Asian and ethnic minority women, asylum seekers, migrant women and refugees. | 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 Midwife 1 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, examsples 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> |
| 8 | SCM1 | **Access to antenatal care and booking appointment**  Infection control | How are infection control measures impacting on pregnant women, partners and families? Pregnant women and known to be more vulnerable to a covid infection by virtue of being pregnant. Some pregnant women will have exiting morbidities which make them more vulnerable to covid, pregnancy aside. The same may be said of partners and other family members attended to support the woman accessing care. And lets not forget we are all vulnerable to long covid. How will the next steps on infection prevention and control letter impact on pregnant woman and their antenatal care.    <https://www.england.nhs.uk/publication/national-infection-prevention-and-control/> |  |
| 9 | SCM1 | **Access to antenatal care and booking appointment**  Access to all antenatal care - and consideration for how access to NHS care has changed during the pandemic. | How would a woman now book into antenatal care - visiting the GP may no longer be an option, some do not have suitable on line access and some women may struggle with telephone calls (benefitting more from face to face of video calls). A variety of options was considered as part of then Guideline process but I wonder how this has changed for women as the pandemic has progressed? |  |
| 10 | SCM3 | **Access to antenatal care and booking appointment**  Equality and Diversity | Majority of the women included in MBBRACE 2020 report, who died from COVID-19 were from black or other minority ethnic groups.  <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf> | Women with complex social factors as per the guideline below  <https://www.nice.org.uk/guidance/cg110>  should be offered **face to face** appointments with patient information leaflets available in most languages.  Ensure that communication with women and partners is via an interpreting service. |
| 11 | SCM4 | **Access to antenatal care and booking appointment**  (currently in standards)  Quality statement 1: Services – access to antenatal care | Following COVID-19 lockdown, many hospitals combined booking appointments and first trimester dating scans, meaning that women booked after the QS1 recommendation of 10+0/40.  Many hospitals are still using an altered care schedule so it is vital that clarity is provided as to whether this can continue.  Also, thought needs to be had as to whether this appointment or contact can be remotely, via telephone. This means that vital signs and blood tests are often not taken until the dating scan (past 10/40). | The [PHE Antenatal Screening Guidance](https://www.gov.uk/government/publications/handbook-for-sickle-cell-and-thalassaemia-screening/antenatal-screening) stipulates that booking blood tests (including screening for haemoglobinopathies) needs to be taken by 10/40. NICE Antenatal Care guidelines also stipulate a booking should be arranged for a woman prior to 10/40. |
| 12 | SCM4 | **Access to antenatal care and booking appointment**  (new suggestion)  Where English is not a woman’s first language | Another outcome of the Ockenden report was care provision for those who do not speak English as a first language.  This means the consistent provision of interpreting services (in either a remote or face to face capacity) as well as translated leaflets. | As above. |
| 13 | SCM5 | **Access to antenatal care and booking appointment**  Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days. | Timely access to antenatal care will help improve early recognition of specific individual needs and risk factors and enable initiation of appropriate antenatal care pathway. | [MBRRACE-UK (2021) Saving lives, improving mothers’ care](https://www.npeu.ox.ac.uk/mbrrace-uk/reports)  [MBRRACE-UK (2021) UK perinatal surveillance reports](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) |
| 14 | Birth Trauma Association | **Risk assessment and referral** | 4) There should be the opportunity for partners to attend, but also consider that some women do need privacy to talk away from their partners especially if there is any domestic abuse or coercive behaviour. |  |
| 15 | Birth Trauma Association | **Risk assessment and referral** | 5) Aim to create a positive relationship between all health professionals involved in antenatal care; providing a consistent model for all areas of the UK, not a post code lottery. |  |
| 16 | Birth Trauma Association | **Risk assessment and referral** | Additional statement  Pregnant women who are offered referrals should have an opportunity to discuss their options with an appropriately qualified health care professional. |  |
| 17 | Fatherhood Institute | **Risk assessment and referral**  Data Collection | Around two-thirds of fathers-to-be are present with their partner when the pregnancy is confirmed (Alderdice et al., 2016; Redshaw & Henderson, 2015) and others are at the ‘booking’ appointment. However, even when the father is sitting beside his pregnant partner, the NHS ‘Pregnancy Notes’ direct the HCP to ask her the questions relating to him: age, citizenship status, mental health; medical issues in his family; whether ‘anyone at home’ smokes or whether there are drug/ alcohol issues ‘in the home’. Questions not asked about the father/ her partner, which could reveal vulnerabilities significant to the whole family include his substance use, his housing circumstances, employment, benefits, education, disability, diet, exercise and physical health. Space on the form is only available to record the expectant mother’s questions/ comments, and notes on her employment rights and benefits, healthy eating, home safety, parent education, and parent/ infant communication.  <http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf> (page 26) | The NHS’ confidence in the expectant mother’s ability to provide accurate information about the father and his family may be misplaced72. Asking the expectant father directly is likely to result in more accurate information and would have the added benefit of acknowledging him and his role as a father (Seale et al., 2008). <http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf> (page 26) |
| 18 | Fatherhood Institute | **Risk assessment and referral**  Antenatal appointments | Since expectant fathers are not invited to NHS antenatal care appointments with their partner, and since prior to April 2015 had no statutory right to time off work to do so, it is remarkable how many attend: a 2010 survey found first-time mothers reporting that 73.3% of their partners had attended at least one routine appointment (Redshaw & Heikkila, 2010). <http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf> page 28  When more specific questions were asked in 2018, in the How was it for you? survey, 29.4% of the fathers-to-be who had attended an antenatal appointment revealed that they had ‘rarely’ or ‘never’ been spoken to directly and 55.6% that they had rarely or never been addressed by name. Only 35% reported that the father’s role had ‘always’ or ‘often’ been discussed. Encouragement-to-ask-questions or raise concerns was more likely to be given during or after the birth than before it: 28.5% of expectant fathers attending routine antenatal appointments, 28.1% attending ultrasound scans, 41.7% attending the birth and 39.8% a post- birth home-visit had ‘often’ experienced such encouragement (Fatherhood Institute & Fathers Network Scotland, 2018). Though not directly comparable, in 1998, 45% of the postal-survey-fathers felt they had been ‘encouraged to ask all their questions’ (Newburn & Singh, 2000). This suggests either that HCPs were more encouraging in 1998 or (possibly more likely) that fathers in 2018 are more knowledgeable and have more potential questions to ask.  In the UK, the How was it for you? survey revealed that some midwives seem to be deviating from their official ‘script’ to ask some fathers direct questions. However, despite the risks of passive smoking to babies, and the impact of fathers’ smoking behaviour on mothers’, only 48% of the fathers-to-be had been asked about their own smoking. Despite known correlations between couples’ health and health behaviours, only 18% had been asked about their own mental health and only 18% their diet and exercise patterns (Fatherhood Institute & Fathers Network Scotland, 2018).  Research finds a clear link between the mother’s and the father’s smoking: in Alspac, by far the biggest predictor of the pregnant woman's current smoking status was her partner’s, with Alspac mothers four times more likely to smoke if their partner smoked (Penn & Owen, 2002). MCS mothers were less likely to quit if their partner continued smoking, and more likely to cut down if he did (Prady et al., 2012). <http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf> (page 22) | Inform the mother-to-be that she is welcome to bring her partner to antenatal appointments and classes. [NICE antenatal care guideline 1.1.14]  Consider the possibility of a partner attending antenatal appointments virtually. [NICE antenatal care guideline 1.1.6]  At the first antenatal appointment, if the partner is present, explain to both mother-to-be and partner how antenatal care will be offered, including a schedule of antenatal appointments. Explain how mothers-to-be and their partners can support each other during the pregnancy. [NICE antenatal care guideline 1.3.7]  Ask about the family history of both biological parents. [NICE antenatal care guideline 1.2.1]  Ask the partner if he/she has any concerns they would like to discuss. [NICE antenatal care guideline 1.2.10]  Explore the understanding of the partner of topics under discussion. [NICE antenatal care guideline 1.3.5]  If the mother-to-be or her partner smokes or has stopped smoking within the past 2 weeks, offer referral to NHS Stop Smoking Services. [NICE antenatal care guideline 1.2.4] |
| 19 | National FASD | **Risk assessment and referral**  Risk assessment | Risk assessment should be carried out about regarding alcohol use in pregnancy. All women should be asked about alcohol use and should be given - take home printed information about the risks of alcohol in pregnancy – targeted at hard to reach groups – BMA, 2007  (NICE QS204)  They ensure that antenatal appointments include verbal and written advice not to consume alcohol in pregnancy)  Alcohol is a teratogen yet not being treated like other teratogens that require being on a pregnancy prevention program like Roaccutane.  Alcohol can cause permanent physical, neurodevelopmental and behavioural disabilities.  It is estimated over 40% of women drink alcohol in pregnancy.  NICE QS 204 (2022) states that all pregnant women should be asked about alcohol use throughout pregnancy.  This should be sensitively done and using motivational interviewing and brief intervention strategies.  Alcohol screening tools like AUDIT-C, can be used but are less effective at identifying low level alcohol.  Asking about alcohol -  ‘This allows personalised discussions about the risks of alcohol use as part of routine healthcare throughout pregnancy. It also gives opportunities to offer tailored support and interventions if the woman wishes to cut down or stop drinking. This may reduce risks and improve outcomes for the mother and baby. Women should be asked about their alcohol consumption in a sensitive, non-judgemental way. Women who wish to discuss their alcohol use should be asked about the quantity, frequency and pattern of drinking, and this should be documented in their maternity records. This information may also help support early diagnosis and treatment for children with fetal alcohol spectrum disorder (FASD).’  **‘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’  Antenatal appointments may need additional time to conduct this screening.  Prenatal Alcohol Exposure (PAE) can also be identified through biomarkers  Midwives should be trained in understanding the risks of alcohol harm during pregnancy such as increased risk of miscarriage, premature birth, still birth as well as sudden infant death syndrome.  Midwives should have training on the prevalence of FASD (Fetal Alcohol Spectrum Disorder) and its presentation.  Midwives should have training on brief interventions and motivational interviewing. | [Quality statement 1: Advice on avoiding alcohol in pregnancy | Fetal alcohol spectrum disorder | Quality standards | NICE](https://www.nice.org.uk/guidance/qs204/chapter/Quality-statement-1-Advice-on-avoiding-alcohol-in-pregnancy)  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  [Alcohol consumption: advice on low risk drinking - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking)  **Error! Hyperlink reference not valid.** |
| 20 | National FASD | **Risk assessment and referral**  Record keeping | Alcohol use in pregnancy should be recorded  Alcohol should be asked about throughout pregnancy and recorded in maternal records.  Mothers may give permission for this to be added to the child’s record in case it is needed later.  **Commissioners** (such as clinical commissioning groups or integrated care systems) commission maternity services that discuss alcohol use during pregnancy at antenatal appointments and record it in the mother's maternity records. They commission services for pregnant women who continue to drink but are not alcohol dependent and for those who are alcohol dependent | [Quality statement 2: Fetal alcohol exposure | Fetal alcohol spectrum disorder | Quality standards | NICE](https://www.nice.org.uk/guidance/qs204/chapter/Quality-statement-2-Fetal-alcohol-exposure) |
| 21 | National Childbirth Trust | **Risk assessment and referral**  Record keeping | The Ockenden Report (2022) clearly highlighted the need for clear record keeping through pregnancy and into the postnatal period. This is to ensure pregnant women, their families, and other health professionals involved in their care, have timely access to accurate information on which to base clinical decisions. Accurate record keeping is also necessary for purposes of incident investigation. | Ockenden, D. (2022). Ockenden Report – Final. Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. London: HMSO. |
| 22 | National Maternity and Perinatal Audit | **Risk assessment and referral**  Provision of health improvement support (such as smoking cessation) and information for pregnant women tailored to their individual circumstances, specifically those with pre-pregnancy health conditions such as diabetes, high blood pressure or a high BMI. | The NMPA fond that having a BMI of 30kg/m2 or above and high blood pressure was more likely in those from Black ethnic groups compared to those from all other ethnic groups. These health conditions were also more common in those women from the most deprived areas, when compared to those from the least deprived areas. Women from South Asian and Black ethnic groups were more likely to have pre-pregnancy diabetes than those from white and Other ethnic groups. Rates of smoking at birth were higher for women from white ethnic groups and those who live in the most deprived areas. | Please see the National Maternity and Perinatal Audit sprint audit report into NHS Maternity Care for Women with a  Body Mass Index of 30 kg/m2 or Above (<https://maternityaudit.org.uk/FilesUploaded/NMPA%20BMI%20Over%2030%20Report.pdf>) |
| 23 | NHS England & Improvement | **Risk assessment and referral** | Documented risk assessment at every antenatal appointment 1.2.10 | Assist with national priorities and work going on around equity/equality and safety/Ockenden response |
| 24 | Royal College of Midwives | **Risk assessment and referral**  Medical complexities in pregnancy | 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) |
| 25 | Royal College of Midwives | **Risk assessment and referral**  Lifestyle intervention services (diet, smoking and physical activity) | 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.  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. | [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)  [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) |
| 26 | SCM4 | **Risk assessment and referral**  (new suggestion)  Risk Assessment | An outcome of the Ockenden report was the importance of risk assessment at every point of contact with a woman during the Antenatal period. This prompts not only the personalisation of care, but a holistic assessment of her needs and requirements for optimal safe care. | Please see the national Ockenden review which highlights the need for risk assessment here: [Final report of the Ockenden review - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review). This is furthermore outlined in the NICE Antenatal Care guidance. |
| 27 | SCM5 | **Risk assessment and referral**  All pregnant women at risk of venous thromboembolism should be referred to an obstetrician for further management. | Venous thromboembolism remains one of the most important causes of direct maternal mortality in the UK.  Recognising all women at risk and initiating appropriate measures offers an opportunity to reduce maternal morbidity and mortality due to this cause. | [MBRRACE-UK (2021) Saving lives, improving mothers’ care](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) |
| 28 | SCM5 | **Risk assessment and referral**  Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment or during their pregnancy. | This intervention offers an opportunity to reduce the complications associated with untreated gestational diabetes, which include  maternal risks- macrosomia, high blood pressure and preeclampsia, birth complications e.g. operative birth, shoulder dystocia, obstetric anal sphincter injury, postpartum haemorrhage  baby risks- preterm birth, stillbirth, jaundice, obesity, and diabetes in later life | <https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf>  [MBRRACE-UK (2021) UK perinatal surveillance reports](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) |
| 29 | SCM5 | **Risk assessment and referral**  At each antenatal contact, ensure that women undergo a formal risk assessment | Early recognition of changing risk status and timely initiation of appropriate care will offer an opportunity to improve maternal and baby outcomes.  It will also be in keeping with the Ockenden report recommendation- formal risk assessment must be undertaken at every antenatal contact so that women can have continued access to care provision by the most appropriately trained professional | [MBRRACE-UK (2021) Saving lives, improving mothers’ care](https://www.npeu.ox.ac.uk/mbrrace-uk/reports)  [MBRRACE-UK (2021) UK perinatal surveillance reports](https://www.npeu.ox.ac.uk/mbrrace-uk/reports)  <https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf> |
| 30 | National Childbirth Trust | **Continuity of carer**  Services - Continuity of care | We fully support the drive to introduce continuity of care for all women. The 2021 National Maternity Survey provides the most recent evidence that people who receive continuity of care report better experiences of maternity services.  As set out in the quality statement, continuity of care is measured by the proportion of women being cared for by a named midwife throughout their pregnancy. The National Maternity Survey data from 2021 shows that only 41% of women received antenatal care from the same midwife. This suggests there is a long way to go before all women receive care from a named midwife. We call on the Government to continue investment in the continuity of care model in maternity services. | Care Quality Commission (CQC) (2021). Maternity Survey 2021. London: CQC. Available at: [Maternity survey 2021 | Care Quality Commission (cqc.org.uk)](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) [accessed 09/05/22] |
| 31 | Royal College of Midwives | **Continuity of carer**  Continuity of carer – different models of care for different groups | - 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. Intervention 1 of this guidance is to implement targeted and enhanced continuity of carer, so that 75% of women in Black, Asian and Mixed ethnic groups and women living in deprived areas receive continuity of carer by 2024.  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) |
| 32 | SCM1 | **Continuity of carer**  Peer Support and information supplemented by group discussions | Access to such groups will also be prevented for some if adequate infection control measures are not put in place, see above. As we 'learn to live with covid' we will be excluding some groups from accessing care and information. |  |
| 33 | SCM4 | **Continuity of carer** (currently in standards)  Quality statement 2: Services – continuity of care | Continuity of Carer is known to improve outcomes for mothers and babies, supporting QS2 that stipulates that every woman should have a named midwife. | Please see the national Ockenden review which discussed Continuity of Carer here: [Final report of the Ockenden review - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review). This report suspended a ‘Continuity of Carer’ model where staffing levels are not sufficient, so acknowledgement of this may be required within the Quality Standards.  A recommendation for continuity of care is also outlined in the National Maternity Review (Better Births) and the NICE Antenatal Care guidance. |
| 34 | SCM3 | **Continuity of carer**  Quality statement 2: Services – continuity of care.... use of Midwifery Continuity of care model needs to be revisited in view of Ockenden Report 2022 | Ockenden Report 2022 has suggested all trusts must demonstrate staffing meets safe minimum requirements on all shifts  <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review> | All trusts must review and suspend, if necessary, the existing provision and further roll-out of midwifery continuity of carer model (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.  The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.  <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review> |
| 35 | GPs Championing Perinatal Care | **Monitoring fetal growth and wellbeing**  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 | Do all HCPs know this? Do GPs, Primary care nurses, psychiatrists etc who may come into contact with pregnant women? | This is part of the Saving mothers’ lives care bundle 2 and will be well known to midwives and obstetricians, but not to other HCPs who come into contact with pregnant women  Recommended in NICE NG201 Evidence review. Fetal movement monitoring |
| 36 | SCM3 | **Monitoring fetal growth and wellbeing**  Risk assessment at booking for determining pathways of care that is routine low risk or high risk, for example:  Documentation of birth centile of previous babies (if applicable)  In case of previous emergency caesarean section, documentation of cervical dilatation at caesarean section | Health care professionals can miss commencing aspirin, arranging uterine dopplers and serial growth scans in the current pregnancy if previous birth centile is not highlighted. This can result in poor outcome.  Emergency caesarean section at full dilatation is an intermediate risk factor for preterm labour. Usually, is missed in history as mostly it is documented as just emergency cs and not explored further therefore missing the chance of offering surveillance in PTB (Preterm Birth) Clinic. | It is important to take a full history from women **who have had a previous baby with FGR a**nd/or a preterm delivery to determine whether placental dysfunction was a contributory factor. Aspirin as a preventative medication appears to be safe in pregnancy and therefore there is a substantial net benefit of daily aspirin use to reduce the risk for preeclampsia and associated preterm birth. Aspirin is therefore recommended from the first to the third trimester of pregnancy in women, following risk assessment at their pregnancy booking visit. Page 52, SBLv2  Please see figure 6 on page 57 of SBL V2, which suggests previous SGA and previous FGR require aspirin and dopplers and ultrasound scans at various gestation  <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>  As per SBL pathway V2, page 63, Surveillance is required:  1) Refer to preterm birth prevention clinic by 12 weeks.  2) Further risk assessment based on history +/- examination as appropriate in secondary care with discussion of option of additional risk assessment tests, including:  a) A single transvaginal cervix scan between 18-22 weeks as a minimum….  <https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/> |
| 37 | GPs Championing Perinatal Care | **Common problems during pregnancy and vaccination**  Pregnant women withnausea andvomiting in pregnancy should have rapid access to a full range of effective pharmacological and non-pharmacological treatments, including Out-Patient IV fluids | The guideline identified effective treatments (ginger, metoclopramide and ondansetron) and also ineffective treatments (cyclizine, which is the most commonly used treatment)  We know that this causes huge mental and physical stress to women in pregnancy  Women need choices and the ability to get on top of this problem rapidly because of its debilitating effects and co-morbidities | NICE NG201 Guideline Review on nausea and vomiting in pregnancy |
| 38 | GPs Championing Perinatal Care | **Common problems during pregnancy and vaccination**  Pregnant women should be encouraged by all health professionals to have the immunisations recommended in pregnancy and flagged for immunisation needed after delivery, such as MMR | Good evidence that these are effective, but rates of uptake are poor. This has been highlighted by Covid, but also applies to flu and pertussis. Uptake of influenza vaccination is low amongst pregnant women (45.2% in 2018/19).  70.5% pregnant women in the UK had the pertussis vaccination in 2018/19. | [COVID-19 Resource Hub: Vaccines in pregnancy screencast (rcgp.org.uk)](https://elearning.rcgp.org.uk/mod/page/view.php?id=13028)  Pertussis  [Green Book Chapter 24 v3\_0 (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/514363/Pertussis_Green_Book_Chapter_24_Ap2016.pdf)  Influenza  [The Green book of immunisation - chapter 19 influenza (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/931139/Green_book_chapter_19_influenza_V7_OCT_2020.pdf)  COVID-19  [COVID-19 Greenbook chapter 14a (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1057798/Greenbook-chapter-14a-28Feb22.pdf)  MMR  <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwikt-G4rdD3AhWON8AKHXdOA9cQFnoECCIQAQ&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fvaccine-in-pregnancy-advice-for-pregnant-women%2Fmmr-measles-mumps-rubella-vaccine-advice-for-pregnant-women&usg=AOvVaw2wTN_bti3g211LLqTrRn8w> |
| 39 | Pelvic Obstetric and Gynaecological Physiotherapy | **Common problems during pregnancy and vaccination**  To consider the impact that PGP can have on some ladies’ function and QoL and to consider identifying that those women are at risk of severe pain or developing chronicity. To address the psychosocial issues or the effect of PGP on women’s mental health, following references |  | Clintonc SC et al (2017) PGP in the antepartum population: Physical Therapy Clinical Practice Guidelines linked to the International Classification of Function, Disability and Health from the section on women’s health and orthopaedic section of the American Physical Therapy Association. Journal of Women’s Health Physical Therapy, 41 (2), 102-125.  Beales D et al (2020) Understanding and managing pelvic girdle pain from a person-centred biopsychosocial perspective. Musculoskeletal Science and Practice, 48: 102152. |
| 40 | Pregnancy Sickness Support | **Common problems during pregnancy and vaccination**  Nausea and vomiting of pregnancy and hyperemesis gravidarum care and treatment | Our charity receives thousands of calls per year from women receiving poor care, or being denied treatment for this condition. | Nausea and vomiting of pregnancy and hyperemesis gravidarum care and treatment |
| 41 | SCM4 | **Common problems during pregnancy and vaccination**  (new suggestion)  Vaccines in pregnancy | All women should be offered COVID-19 (in line with national vaccination programmes), pertussis and influenza (in season) vaccines during pregnancy. | Pertussis vaccine is recommended to pregnant women to prevent against acute neonatal pertussis illness - [Pertussis vaccine | Treatment summary | BNF content published by NICE](https://bnf.nice.org.uk/treatment-summary/pertussis-vaccine.html)  Influenza and COVID-19 vaccines are also recommended as safe in pregnancy and should be encouraged in line with [RCOG](https://www.rcog.org.uk/guidance/coronavirus-covid-19-pregnancy-and-women-s-health/vaccination/covid-19-vaccines-pregnancy-and-breastfeeding-faqs/) and [NICE](https://cks.nice.org.uk/topics/immunizations-seasonal-influenza/) advice. |
| 42 | Birth Trauma Association | **Information and support** | 1) Make sure that every pregnant woman is offered antenatal education that provides a neutral, evidence-based explanation of what birth involves, including potential risks. |  |
| 43 | Birth Trauma Association | **Information and support** | 2) Make sure that every pregnant woman is given the opportunity to make an informed decision about choices during birth based on an assessment of her individual risk profile, including factors such as age, ethnicity, height, weight and obstetric history. |  |
| 44 | Fatherhood Institute | **Information and support**  Engagement with Partners/Fathers: | Despite the issuing of policy guidance over the past decade or so stipulating that fathers/mother’s partners should be engaged in maternity care and education, engagement with fathers in maternity systems continues to be conditional and their experience variable – dependant on the policies or approaches of individual NHS trusts, maternity policies and staff attitudes.  Covid-19 revealed how important partner engagement is to women – 427,000 people signed a petition to end the practice of separating women and their birth-partners/babies fathers’ during labour (<https://www.change.org/p/nhs-protect-the-right-to-have-a-birth-partner-during-covid-19>)  The Antenatal Care guideline broke new ground in relation how partners should be engaged during antenatal care, highlighted in the publicity that NICE organised around the launch of the guideline. “For the first time, the guideline addresses the role that partners can play in supporting women through their pregnancy.” (<https://mailchi.mp/nice/nice-update-for-primary-care-august-210825>).  This area of maternity care is subject to widely different approaches and much inconsistency. Covid-19 revealed how important partner engagement is to women – 427,000 people signed a petition to end the practice of separating women and their partners. (<https://www.change.org/p/nhs-protect-the-right-to-have-a-birth-partner-during-covid-19>) | Example:  In light of a robust body of research internationally, demonstrating associations between expectant and new fathers’ behaviour, experiences, attitudes and characteristics, and maternal and infant health and wellbeing, the World Health Organisation has set out, among ten recommendations on health promotion interventions for maternal and new-born health, a recommendation (‘Recommendation Two’) on engaging fathers:  Interventions to promote the involvement of men during pregnancy, childbirth and after birth are recommended to facilitate and support improved self-care of women, improved home care practices for women and new-borns, improved use of skilled care during pregnancy, childbirth and the postnatal period for women and new-borns, and to increase the timely use of facility care for obstetric and new-born complications. (World Health Organisation, 2015) (p.3)  “In the UK professional bodies, including the Royal College of Obstetricians and Gynaecologists (RCOG, 2017), NHS England (National Maternity Review, 2016), Barnardo’s (Cundy, 2012), the NSPCC (Hogg, 2014), the Royal College of Midwives, endorsed by the Department of Health (RCM, 2011) and the National Institute for Health and Clinical Excellence (NICE, 2010a) have also advised healthcare practitioners (HCPs) to engage fathers or ‘mothers’ partners’ in maternity care and education.“ <http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf> )  Throughout Britain, almost all births (95%) are now registered by mother and father together  <http://www.fatherhoodinstitute.org/2021/dads-shut-out-fathers-and-maternity-services-during-the-pandemic/> |
| 45 | Fatherhood Institute | **Information and support**  Information about parenting, relationships, support | Inform the mother-to-be that she is welcome to bring her baby’s father or a partner to antenatal appointments and classes. [NICE antenatal care guideline 1.1.14]  Consider timing the antenatal classes so that the baby’s father or a partner can attend. [NICE antenatal care guideline 1.1.15]  Offer antenatal classes to all first-time mothers-to-be and their baby’s fathers/partners. These classes will include discussion about:  How mothers-to-be and baby’s fathers, or partners can operate as a parenting team, reduce parental conflict and support each other  How to care for a baby  How parents can bond with the baby and the importance of emotional attachment. [NICE antenatal care guideline 1.3.19,20] |  |
| 46 | NHS England & Improvement | **Information and support** | Information provided to support decision making should meet NICE guidance. |  |
| 47 | National Maternity and Perinatal Audit | **Information and support**  Provision of breastfeeding information and support during pregnancy, tailored to the woman or pregnant person’s specific needs.  This support should be targeted in areas where breast feeding rates are lowest. | The NMPA found that rates of receiving breast milk at the first feed were lowest for babies born to women from white ethnic groups and those from the most deprived areas. | Please see the National Maternity and Perinatal Audit sprint audit report into NHS Maternity Care for Women with a Body Mass Index of 30 kg/m2 or Above (<https://maternityaudit.org.uk/FilesUploaded/NMPA%20BMI%20Over%2030%20Report.pdf>) and Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies (<https://maternityaudit.org.uk/FilesUploaded/Ref%20308%20Inequalities%20Sprint%20Audit%20Report%202021_FINAL.pdf>). |
| 48 | National Maternity and Perinatal Audit | **Information and support**  Provision of maternity care information to those with a BMI above 30kg/m2 or above, tailored to their individual circumstances. | This includes information relevant for the different categories of BMI as well as whether is it a first birth or a birth after a previous caesarean.  The NMPA found that the likelihood of a woman experiencing an intrapartum intervention or adverse maternal outcome, or her baby experiencing very serious complications following birth, increases as BMI increases. W:  For example, the likelihood of experiencing a caesarean birth, severe bleeding after birth, or needing to be admitted to hospital after the birth increases as BMI increases. | Please see the National Maternity and Perinatal Audit sprint audit report into NHS Maternity Care for Women with a  Body Mass Index of 30 kg/m2 or Above (<https://maternityaudit.org.uk/FilesUploaded/NMPA%20BMI%20Over%2030%20Report.pdf>) |
| 49 | National Maternity and Perinatal Audit | **Information and support**  Provision of information made available to all women about their choices during pregnancy and labour. This includes ways to promote informed and shared decision-making about where, how and when to give birth as well as options for pain relief. | The NMPA found that having a birth without intervention (BWI\*) was more likely for women from Black ethnic groups; as was any type of caesarean birth (planned caesarean, emergency or both combined); and experiencing a severe blood loss, than for those from white ethnic groups.  Women in the most deprived areas had lower rates of severe blood loss after childbirth than those living in less deprived areas. | Please see the National Maternity and Perinatal Audit sprint audit report into NHS Maternity Care for Women with a  Body Mass Index of 30 kg/m2 or Above (<https://maternityaudit.org.uk/FilesUploaded/NMPA%20BMI%20Over%2030%20Report.pdf>) |
| 50 | NHS England & Improvement | **Information and support** | Standardise equipment and consultation and referral guidance in midwife led settings (AMU, FMU,home) | This is in response to the recent paper from NPEU showing wide variation. |
| 51 | Royal College of Midwives | **Information and support**  Informed decision support and personalised care planning | -Pregnant women receive many public health messages that are intended to guide their decision making; intended to improve outcomes for babies and mothers. The focus within the maternity services must be on ensuring that the information that is provided is appropriate - clear, factual, culturally tailored. The advice given is often not understood or is not culturally adapted and this can lead to the advice not being adhered to.  The NHS Long Term Plan and the Universal Personalised Care guidance, made commitments to deliver choice and personalised care in maternity services. The Maternity Programme supports Local Maternity Systems (LMS) to improve choice and deliver personalised care for women and their families.  Informed decision making is a central part of personalised care and support planning. It means that anyone receiving care is fully supported and informed to understand the options, decisions and care that they will have.  Informed decision-making means that everyone receiving maternity care understand the options available and the risks and benefits of these options; can make decisions about their care; receive reliable, clear information in good time and in a format they understand.  The WRISK Project and IDECIDE tool can offer support when facilitating informed decision making and in designing tailored and accessible resources. | [RCM Informed decision making briefing](https://www.rcm.org.uk/media/5989/informed-decision-making_0604.pdf)  [WRISK project](https://www.pslhub.org/learn/patient-safety-in-health-and-care/high-risk-areas/maternity/the-wrisk-project-understanding-and-improving-the-communication-of-risk-relating-to-pregnancy-r4934/)  [NHS England - Personalised care and support planning guidance for LMS](https://www.england.nhs.uk/wp-content/uploads/2021/03/B0423-personalised-care-and-support-planning-guidance-for-lms.pdf) |
| 52 | SCM2 | **Information and support**  Engagement with partners. | The Antenatal Care guideline broke new ground in relation how partners should be engaged during antenatal care. This was highlighted in the publicity that NICE organised around the launch of the guideline. For example, NICE announced the guideline to GPs in this way: “For the first time, the guideline addresses the role that partners can play in supporting women through their pregnancy.” (<https://mailchi.mp/nice/nice-update-for-primary-care-august-210825>).  12 new specifications cover four areas:   * A welcoming environment * Antenatal appointments * Information about parenting, relationships, support * Antenatal classes   I have listed the 12 specifications in an article I wrote about the guideline: https://familyincluded.com/partners-nice-antenatal-guideline/  These specifications constitute a systematic approach to better engagement with families/fathers but they are distributed across the guideline and do not appear together.  This area of maternity care is subject to widely different approaches and much inconsistency. Covid-19 revealed how important partner engagement is to women – 427,000 people signed a petition to end the practice of separating women and their partners. (<https://www.change.org/p/nhs-protect-the-right-to-have-a-birth-partner-during-covid-19>)  Applying a set of standards to this area of practice for the first time will require focus and patience. Hence my recommendation that engagement with partners is highlighted as a priority area of practice improvement. |  |
| 53 | SCM5 | **Information and support**  Check that the woman (and her partner) understands the information that has been given, and how it relates to them. | Key principles of care is to truly listen to women, support them with information which is evidence-based, relevant to their circumstances and responsive to their need.  Recognising the groups over-represented in the national maternal mortality reports, it is vital that professionals seek reassurance that information provided has been understood and enables shared decision making. | [MBRRACE-UK (2021) Saving lives, improving mothers’ care](https://www.npeu.ox.ac.uk/mbrrace-uk/reports)  <https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf>  <https://www.supremecourt.uk/cases/uksc-2013-0136.html> |
| 54 | British Medical Ultrasound Society | **Additional areas**  Use of Doppler during ultrasound scans to monitor foetal growth. | Different care pathways are available such as the RCOG SGA pathway and the NHS SBLCBv2 but there is a lack of standardised ultrasound practice in antenatal departments leading to variations in care. Advice may be needed on which maternal or foetal vessels to sample and when. | Please see 2022 BMUS guidance stating the lack of national guidance on how to best use ultrasound after 23 weeks’ gestation (for growth scans).  [SIG3\_document\_FINAL\_\_v\_16\_\_27\_Jan\_2022-\_With\_cover\_QcOJnLN.pdf (bmus.org)](https://www.bmus.org/static/uploads/resources/SIG3_document_FINAL__v_16__27_Jan_2022-_With_cover_QcOJnLN.pdf) |
| 55 | Birth Trauma Association | **Additional areas** | Also please see below for recommendations on the language used:  Would like to replace this ('refer' with the word 'offer')  Statement 5 Pregnant women who smoke are referred for evidence-based stop-smoking support at the booking appointment.  With this including the word 'offer':  Statement 5 Pregnant women who smoke should be engaged in a discussion about smoking cessation and offered a referral for evidence-based stop-smoking support at the booking appointment.  Replace  Statement 8 Pregnant women at risk of venous thromboembolism at the booking appointment are referred to an obstetrician for further management.  With  Statement 8 Pregnant women at risk of venous thromboembolism at the booking appointment are offered a referral to an obstetrician for further discussion of their care options. |  |
| 56 | The Down's Syndrome Association | **Additional areas**  Women who receive a higher-chance result from a fetal anomaly screening test | The focus of the current Quality Standard is on the offer (and uptake of) antenatal screening tests. There is no Quality Standard that relates to women’s experience of support following a higher chance result. The pathway supports women who want no further testing; women who want additional invasive testing to obtain a confirmed prenatal diagnosis (either for information to support choices as they continue their pregnancy or in order to terminate the pregnancy). Over the last decade, there have been numerous occasions when a pathway for women continuing a pregnancy with a prenatal diagnosis of a chromosomal condition has been mentioned, but this has never been developed. The need for this is even more timely due to the recent launch of the offer of NIPT for Down’s syndrome, Edward’s syndrome and Patau’s syndrome within NHS settings across England in 2021. It is clear that good quality information, non-directive counselling and referral to condition-specific Third Sector support organisations is needed in these circumstances. We would like to see a Quality Standard that focuses on the provision of support following a higher-chance antenatal screening test result and the development of a co-produced pathway for women continuing their pregnancy with a prenatal diagnosis of a chromosomal condition. | The Nuffield Council on Bioethics Report on proposed introduction of Non-Invasive Prenatal Testing (2017) <https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing>  Royal College of Obstetricians and Gynaecologists Antenatal care routine care for the healthy pregnant woman,<https://elearning.rcog.org.uk//sites/default/files/Fetal%20growth%20restriction/nice_guideline_p277.pdf>  The Down's Syndrome Association Tell it Right campaign [Campaigning - Downs Syndrome Association (downs-syndrome.org.uk)](https://www.downs-syndrome.org.uk/our-work/campaigning/#tell) |
| 57 | GPs Championing Perinatal Care | **Additional areas** | Information sharing with GP should be routine for every pregnant woman, with the woman’s permission, even if there are no apparent causes for concern | There are recurrent examples in MBRRACE cases where information has not been shared to the detriment of outcomes. This is especially the case with previous mental illness  Good practice that the GP knows the woman is pregnant |
| 58 | Royal College of Nursing | **Additional areas**  Specify responsibility for follow up | HBA1c post-partum for women with GDM to be done by the GP  Ambiguity in whose responsible this leads to the test not being done. GP’s to carry out testing | [Barriers to postpartum diabetes screening: a qualitative synthesis of clinicians’ views - PMC (nih.gov)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8103924/) |
| 59 | Royal College of Nursing | **Additional areas**  Include health inequalities for women with GDM or pre-existing Diabetes at risk populations travelling communities, homelessness, learning disabilities, BAME | A review to address health inequalities amongst women with gestational diabetes & or existing diabetes | [Research reveals health inequalities for Black and South Asian women following gestational diabetes diagnosis | News | University of Leicester](https://le.ac.uk/news/2022/march/gestational-diabetes) |
| 60 | Society and College of Radiographers | **Additional areas**  QS1 Equality and diversity considerations | Inclusivity within the document, particularly in relation to trans and non-binary parents, who often have complex needs, is not clear. The terminology ‘women’ throughout the document is not in keeping with inclusivity in a population that are at increased risk of health inequalities.  To support access to antenatal care, the term ‘women and pregnant people’ or similar would be more inclusive and potentially improve access to services and reduce the number of trans and non-binary people freebirthing. | Please see Trans and Non-binary Experiences of Maternity Services (ITEMS) report <https://lgbt.foundation/news/revealed-improving-trans-and-non-binary-experiences-of-maternity-services-items-report/475>  and  Gender Inclusive Language in Perinatal Services: Mission Statement and Rationale <https://www.bsuh.nhs.uk/maternity/wp-content/uploads/sites/7/2021/01/Gender-inclusive-language-in-perinatal-services.pdf> |
| 61 | SCM3 | **Additional areas** | Quality statement 8: Risk assessment – venous thromboembolism (VTE)  Consider vaping with nicotine-filled e- cigarettes as a risk factor for VTE like smoking- which is considered as a risk factor of 1 for VTE risk score | NICE CG 209 did not identify any effectiveness or safety evidence about using e-cigarettes for smoking cessation during pregnancy in which case, till such data is available, consider vaping as a VTE risk factor.  Evidence below suggests e-cigarettes are not without risks  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8372638/>  <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/e-cigarettes-pregnancy.htm>  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6486852/> |
| 62 | SCM3 | Quality statement 6: Risk assessment – gestational diabetes (GDM):  Include use of quetiapine or olanzapine as a risk factor for GDM | Second generation antipsychotic medications (SGAs) are widely used by reproductive-age women to treat a few psychiatric illnesses. Some SGAs have been associated with an increased risk of developing diabetes.  Women who used antipsychotics during pregnancy have increased risk of gestational diabetes  R. Boden, M. Lundgren, L. Brandt, J. Reutfors, H. Kieler. Antipsychotics during pregnancy: relation to fetal and maternal metabolic effects. Arch. Gen. Psychiatry, 69 (7) (2012), pp. 715-721  Johan Reutfors et al. Antipsychotic drug use in pregnancy: A multinational study from ten countries. Schizophrenia. Research, Volume 220, 2020, Pages 106-115 | Monitor for GDM in pregnant women taking antipsychotic medication and offer an OGTT (Oral Glucose Test). Point 1.4.25 in NICE CG 192 |
| 63 | Society and College of Radiographers | **Additional areas** | QS7 inclusion of PET is valuable | There is anecdotal evidence of covert screening for PET, using PAPP-A results, in the low risk population in some units, without valid informed consent or being part of a screening programme. |