NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Antenatal care

NICE quality standard

Draft for consultation

August 2022

September 2012

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| **This quality standard covers** the routine antenatal care that women and their babies should receive during pregnancy. The quality standard uses the term 'woman' or 'mother' and should be taken to include people who do not identify as women but who are pregnant. The term ‘partner’ refers to the woman’s chosen supporter. This could be the baby's father, the woman’s partner, a family member or friend, or anyone who they feel supported by or wish to involve. The term 'parents' refers to those with the main responsibility for the care of a baby. This will often be the mother and the father, but many other family arrangements exist, including single parents.It does not cover the care and management (beyond identification and referral) of specific physical conditions, mental health conditions and antenatal complications. These are covered by other quality standards: [diabetes in pregnancy](https://www.nice.org.uk/guidance/qs109), [intrapartum care: existing medical conditions and obstetric complications](https://www.nice.org.uk/guidance/qs192), [antenatal and postnatal mental health](https://www.nice.org.uk/guidance/qs115), [ectopic pregnancy and miscarriage](https://www.nice.org.uk/guidance/qs69), [multiple pregnancy: twin and triplet pregnancies](https://www.nice.org.uk/guidance/qs46), [hypertension in pregnancy](https://www.nice.org.uk/guidance/qs35), [preterm labour and birth](https://www.nice.org.uk/guidance/qs135) and [caesarean birth](https://www.nice.org.uk/guidance/qs32).This quality standard will update and replace the existing quality standard on antenatal care (published September 2012). The topic was identified for update following the annual review of quality standards. The review identified: * changes in the priority areas for improvement.
* updated guidance on [antenatal care](https://www.nice.org.uk/guidance/ng201/).

For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).This is the draft quality standard for consultation (from 11 August to 15 September 2022). The final quality standard is expected to publish by February 2023.  |

# Quality statements

[Statement 1](#_Quality_statement_1:) Pregnant women are supported to access antenatal care by 10 weeks of pregnancy. **[2012, updated 2022]**

[Statement 2](#_Quality_statement_2:_1) Pregnant women have a risk assessment at routine antenatal appointments. **[2012, updated 2022]**

[Statement 3](#_Quality_statement_3:) Pregnant women have access to a named midwife. **[2012, updated 2022]**

[Statement 4](#_Quality_statement_4:) Pregnant women are offered vaccinations at routine antenatal appointments. **[new, 2022]**

[Statement 5](#_Quality_statement_5:) Pregnant women and partners who smoke are referred for stop-smoking support at routine antenatal appointments. **[2012, updated 2022].**

In 2022 this quality standard was updated, and statements prioritised in 2012 were updated (2012, updated 2022) or replaced (new 2022). For more information, see [update information](#_Update_information_2).

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| Questions for consultation Questions about the quality standard**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.Questions about individual quality statements**Question 4 For draft quality statement 3:** In light of the findings of the [Ockenden review (final report published March 2022)](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions) do you have any additional comments on this statement?**Local practice case studies****Question 5** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Access to antenatal care

## Quality statement

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

## Rationale

Supporting women to attend the first antenatal (‘booking’) appointment as early as possible, by 10 weeks of pregnancy, will enable early identification of potential risks and ensure that care is planned according to her needs. This may not always be possible as some women may be unaware of their pregnancy or may choose not to access antenatal care early. Some pregnant women and their babies are at greater risk of adverse outcomes and may need additional support to improve their access to antenatal care.

## Quality measures

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

### Process

The proportion of pregnant women who attended their booking appointment by 10 weeks of pregnancy.

Numerator – the number in the denominator who attended their booking appointment by 10 weeks of pregnancy.

Denominator – the number of pregnant women with an antenatal booking appointment

### Outcome

a) Rates of maternal mortality.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. The [MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reports on the number of maternal deaths attributed to pregnancy and non-pregnancy related causes.

b) Perinatal mortality rates.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. Trusts report on late fetal losses, stillbirths and neonatal deaths (up to 4 weeks of life) as part of reporting on perinatal mortality rates using the [MBRRACE-UK-National Perinatal Mortality Review Tool](https://www.npeu.ox.ac.uk/pmrt) for ongoing audit. The [Maternity Services Dashboard](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) can be used to monitor performance and compare services for stillbirth and neonatal mortality rates.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts and community providers) ensure that local systems are in place to encourage pregnant women to access antenatal care by 10 weeks. They ensure that healthcare professionals tell women that their partner can be involved according to her wishes. They provide accessible information about pregnancy and antenatal care services, a variety of options for women to start their antenatal care, and an easy-to-use referral form. Providers ensure that healthcare professionals have the skills and knowledge they need to support women with complex social factors to access antenatal care.

**Healthcare professionals** (such as GPs, allied health professionals) support pregnant women to access antenatal care by discussing the need for antenatal care with her. They offer a booking appointment in the first trimester, ideally within 10 weeks, if the woman wants to continue the pregnancy. Healthcare professionals involve a pregnant woman’s partner, according to her wishes, and tell her that she is welcome to bring her partner to the booking appointment if she wishes.

**Commissioners** (integrated care systems) ensure that they commission antenatal care services that pregnant women can access easily. Commissioners work with providers to use data and intelligence to improve access to antenatal care for pregnant women at a higher risk of adverse outcomes. This includes pregnant women from black, Asian and minority ethnic family backgrounds, pregnant women living in the most deprived areas and pregnant women with 1 or more complex social factors.

**Pregnant women** can easily find information about pregnancy and how to access antenatal care. They can get a first appointment within the first 10 weeks of pregnancy which means that any problems can be spotted early and that care can be tailored and sensitive to their needs. Pregnant women can also involve their partner (if applicable) in their antenatal care if they wish and can also invite them to attend the booking appointment.

## Source guidance

* [Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201) (2021), recommendations 1.1.1 and 1.1.4.
* [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), recommendations 1.1.11, 1.3.1 and 1.3.5.

## Definitions of terms used in this quality statement

Support to access antenatal care

There should be different ways to start antenatal care, depending on women’s needs and circumstances (for example, by self-referral, or referral by a healthcare professional, a school nurse, community centre or refugee hostel). An easy-to-complete referral form should be provided.

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

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

A variety of methods (for example, text messages) should be used to remind women of upcoming and missed antenatal appointments.

## Equality and diversity considerations

To encourage uptake of antenatal care services by women who are in protected characteristic and vulnerable groups healthcare professionals should:

* offer age-appropriate services in the community
* use a variety of means to communicate
* provide information about help with transportation to and from appointments.

[Adapted from [NICE’s guideline on pregnancy and complex social factors](https://www.nice.org.uk/guidance/cg110), recommendations 1.2.11, 1.3.1 and 1.4.1]

For pregnant women (and if applicable, their partner) with additional needs related to a disability, impairment or sensory loss, information and referral forms should be provided as set out in the [NHS Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/), or the equivalent standards for the devolved nations, to enable them to understand information about accessing antenatal services and how to use them.

# Quality statement 2: Risk assessment

## Quality statement

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

## Rationale

The booking appointment and subsequent routine antenatal appointments are opportunities for ongoing risk assessments on the health and wellbeing of the woman and her baby. Early identification of potential medical, social and emotional risk factors enables organisation of additional, specialist management and support. Ongoing risk assessment and monitoring helps reduce the risk of adverse outcomes for the woman and her baby.

## Quality measures

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

### Process

a) The proportion of booking appointments which included a risk assessment.

Numerator – the number in the denominator which included a risk assessment.

Denominator – the number of booking appointments.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. [NHS Digital’s Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes recording of fetal growth restriction at the booking appointment in support of the [NHS’s Saving babies’ lives care bundle version 2](https://www.england.nhs.uk/mat-transformation/saving-babies/).

b) The proportion of routine antenatal appointments (excluding the booking appointment) which included a risk assessment.

Numerator – the number in the denominator which included a risk assessment.

Denominator – the number of routine antenatal appointments (excluding the booking appointment).

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems.

### Outcome

a) Rates of maternal mortality.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. The [MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reports on the number of maternal deaths attributed to pregnancy and non-pregnancy related causes.

b) Stillbirth rates.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. Trusts report on stillbirth rates as part of reporting on perinatal mortality rates using the [MBRRACE-UK-National Perinatal Mortality Review Tool](https://www.npeu.ox.ac.uk/pmrt) for ongoing audit. [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes data on stillbirths and the [Maternity Services Dashboard](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) can be used to monitor performance and compare services.

c) Neonatal mortality rates.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. Trusts report on neonatal mortality as part of reporting on perinatal mortality rates using the [MBRRACE-UK-National Perinatal Mortality Review Tool](https://www.npeu.ox.ac.uk/pmrt) for ongoing audit. NHS Digital’s [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes data on neonatal mortality and the [Maternity Services Dashboard](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) can be used to monitor performance and compare services

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts and community providers) ensure that local protocols include risk assessment as part of each routine antenatal appointment. They also ensure that referral pathways are in place so that healthcare professionals can make referrals for further management of specific risks at the earliest opportunity.

**Healthcare professionals** (such as midwives or obstetricians) carry out a risk assessment for pregnant women at each routine antenatal appointment and record the outcomes. They refer pregnant women for further management of specific risks at the earliest opportunity.

**Commissioners** (integrated care systems) ensure that they commission antenatal care services that have risk assessment protocols and referral pathways in place, and the capacity to include a risk assessment at each routine antenatal appointment. They monitor providers to ensure that pregnant women have a risk assessment at routine antenatal appointments and that additional care is planned at the earliest opportunity.

**Pregnant women** have ongoing risk assessments at each antenatal appointment. This is so that additional, personalised care can be planned at the earliest opportunity, if it is needed.

## Source guidance

[Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/NG201) (2021), recommendations 1.2.10, 1.2.18, 1.2.21, 1.2.23, 1.2.28 and 1.2.29.

## Definitions of terms used in this quality statement

### Risk assessment

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. [[NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), recommendation 1.2.10]

### Routine antenatal appointments

All pregnant women are offered the booking appointment (by 10 weeks), and appointments at 16, 28, 34, 36, 38 and, for those who have not yet given birth, 41 weeks. Pregnant women who have not given birth before have 3 additional appointments, at 25, 31 and 40 weeks.

[Adapted from [NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), recommendations 1.1.7, 1.1.8, schedule of antenatal appointments and expert opinion]

## Equality and diversity considerations

[MBRRACE-UK reports on maternal and perinatal mortality](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) highlight that women and babies from black, Asian and minority ethnic family backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring and additional support.

Pregnant women should be supported to communicate effectively with healthcare services. They should have access to interpreters, link worker or advocate if needed. Interpreters, link workers or advocates should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

It is important for providers to make reasonable adjustments to support pregnant women with a physical, sensory, cognitive or learning disability to participate effectively in risk assessments. For example, independent British Sign Language interpreting services may be needed. Healthcare professionals may need to plan longer appointments to enable pregnant women and partner (if present) to raise concerns as part of the risk assessment process, confirm correct understanding of information given and how it relates to them, and to ask questions.

 [Adapted from [NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), recommendations 1.3.6 and 1.1.11; [NICE’s guideline on pregnancy and complex social factors](https://www.nice.org.uk/guidance/cg110/), recommendations 1.3.10 and 1.3.11].

# Quality statement 3: Continuity of care

## Quality statement

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

## Rationale

A named midwife, working within a small team of midwives and with other healthcare professionals, has responsibility for ensuring that the needs of the pregnant woman and her baby are met. The named midwife is the main point of contact, coordinating care and sharing information with other healthcare professionals, including with other members of the midwifery team. This helps to ensure consistency of midwifery input and that the wider care team recognises any concerns about the woman or baby’s health.

## Quality measures

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

### Structure

### Evidence of local arrangements to ensure that continuity of carer pathways are in place

### Data source: Data can be collected from information recorded locally by provider organisations, for example, service protocols and local plans.

### Process

The proportion of pregnant women who have a named midwife.

Numerator – The number in the denominator who have a named midwife.

Denominator – The number of pregnant women.

**Data source:** Information on the proportion of women who have a named midwife can be collected from information recorded locally such as antenatal care records.  [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes placement on the continuity of carer pathway and the [Maternity Services Dashboard](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) can be used to monitor performance and compare services.

### Outcome

The proportion of women who report that midwives and doctors were aware of their medical history.

Numerator – The number in the denominator who report that midwives and doctors were aware of their medical history.

Denominator – The number of women who gave birth.

**Data source:** The annual [Care Quality Commission Maternity Survey](https://www.cqc.org.uk/publications/surveys/surveys) collects data about women’s experiences of the continuity of their antenatal care, including: During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?

## What the quality statement means for different audiences

**Service providers** (maternity services) ensure that protocols are in place for women and their babies to have access to a named midwife, who is the main point of contact and enables planning of consistent and individualised care. Providers ensure that systems are in place for information to be shared between healthcare professionals involved in the woman’s care so that any concerns about her or her baby’s health are recognised.

**Healthcare professionals** (midwives) are responsible for planning consistent, individualised care for a woman and her baby throughout the maternity pathway. A named midwife acts as the main point of contact. They communicate and share information with both other midwives in the team and other healthcare professionals in a timely and effective manner, so that any concerns about the woman or baby’s health are recognised.

**Commissioners** (integrated care systems) ensure that they commission services that give women access to a named midwife who ensures that consistent and individualised care is provided. Commissioners work together to ensure that systems are in place to enable information to be shared quickly and easily between and within services in the antenatal period.

**Pregnant women** have access to a named midwife who they can contact and who, working within a small team with other healthcare professionals, coordinates care for her and her baby.

## Source guidance

* [Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201/) (2021), recommendation 1.1.12.
* [[Pregnancy and complex social factors. NICE guideline CG110](https://www.nice.org.uk/guidance/cg110/)](https://www.nice.org.uk/guidance/cg110/) (2010), recommendations 1.2.4, 1.4.4 and 1.5.5.

## Definitions of terms used in this quality statement

### Named midwife

A named midwife takes responsibility for ensuring that the needs of the woman and her baby are met. This involves being the main point of contact and coordinating her care. Through effective communication with both other members of a small midwifery team and other healthcare professionals, consistency of midwifery input is supported and any concerns about the woman or baby’s health are recognised. [Adapted from [NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), terms used in this guideline]

## Question for consultation

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

# Quality statement 4: Vaccination

## Quality statement

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

## Rationale

The influenza (flu) and pertussis (whooping cough) vaccines for pregnant women are included in the [NHS complete routine immunisation schedule](https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule). [Chapter 14a of the UK Health Security Agency's Green Book](https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a) recommends the COVID-19 vaccine for pregnant women. Offering pregnant women these vaccinations at antenatal appointments, if they are eligible to have them, provides them with an opportunity to immunise them and their baby against these infectious diseases. It also increases overall uptake of vaccination.

## Quality measures

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

### Structure

Evidence of local arrangements to ensure that healthcare professionals receive training to discuss and offer vaccinations to pregnant women.

**Data source:** Data from information recorded locally, for example, staff training records.

### Process

a) Proportion of eligible women who received the seasonal flu vaccination during pregnancy.

Numerator – the number in the denominator who received the seasonal flu vaccination during pregnancy.

Denominator – the number of pregnant women eligible for seasonal flu vaccination.

**Data source:** [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes data on vaccination (immunisation) carried out maternity services. The [UK Health Security Agency provides national data on seasonal flu vaccine uptake](https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2020-to-2021) by pregnant women at GP practices, schools, pharmacies and ‘other healthcare settings’. This includes antenatal services, although no breakdown is given. [Seasonal flu vaccine uptake data by GP patients by ethnicity is available for NHS commissioning regions](https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-monthly-data-2021-to-2022). Take-up data disaggregated by ethnicity is available.

b) Proportion of eligible women who received a pertussis vaccination during pregnancy.

Numerator – the number in the denominator who received a pertussis vaccination during pregnancy.

Denominator – the number of pregnant women eligible for pertussis vaccination.

**Data source:** [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes data on vaccination (immunisation) carried out by maternity services. The [UK Health Security Agency provides monthly prenatal pertussis coverage estimates](https://www.gov.uk/government/publications/pertussis-immunisation-in-pregnancy-vaccine-coverage-estimates-in-england-october-2013-to-march-2014) in pregnant women in England by local teams, clinical commissioning group or /integrated care system, and NHS England regions. This uses information submitted by antenatal and other services offering vaccinations to pregnant women through the woman’s registration with a GP.

c) The proportion of eligible women who received vaccination against COVID-19 during pregnancy.

Numerator – the number in the denominator who received vaccination against COVID-19 during pregnancy.

Denominator – the number of pregnant women eligible for vaccination against COVID-19.

**Data source:** [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes data on vaccination (immunisation) carried out by maternity services. The [UK Health Security Agency provides COVID-19 vaccine surveillance reports](https://www.gov.uk/government/publications/covid-19-vaccine-weekly-surveillance-reports) which provide data on coverage among pregnant women, including by the number of doses received by time of delivery and the timing of administration (trimester). Take-up data disaggregated by ethnicity and deprivation quintile is available.

### Outcome

a) Rates hospitalisation and intensive care unit admission in pregnant women due to flu.

**Data source:** Rates of hospital admissions (per 100,000 in England) are collected from submissions from NHS acute trusts through the [Severe Acute Respiratory Infection (SARI) Watch surveillance system](https://www.gov.uk/government/statistics/annual-flu-reports/surveillance-of-influenza-and-other-seasonal-respiratory-viruses-in-winter-2021-to-2022). Data disaggregated by age ranges and region are available.

b) Incidence of pertussis.

**Data source:** that report on national incidence based on laboratory confirmed cases (per 100,000 of the population in England) including within different age groups (including incidence in infants and children of various ages).

c) Rates of hospital admission in pregnant women due to COVID-19.

**Data source:** Rates of hospital admissions (per 100,000 in England) are collected from submissions from NHS acute trusts through the [SARI Watch surveillance system](https://www.gov.uk/government/statistics/annual-flu-reports/surveillance-of-influenza-and-other-seasonal-respiratory-viruses-in-winter-2021-to-2022). Data disaggregated by age ranges, sex, ethnicity and region are available. [Experimental statistics on the incidence of hospital admissions (per 100,000 infections) by pregnancy and vaccination status are available from the Office of National Statistics](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19hospitaladmissionsbyvaccinationandpregnancystatusengland/8december2020to31august2021).

## What the quality statement means for different audiences

**Service providers** (maternity services) ensure that systems are in place to train healthcare professionals to check a pregnant woman’s eligibility for vaccinations and administer vaccines during the booking appointment and other routine antenatal appointments. They ensure that appointments have enough time for discussion, so healthcare professionals can identify and address any concerns, gain informed consent, administer the vaccine and complete documentation. Providers have protocols to ensure that if staff cannot give the vaccination during the appointment, they signpost women to vaccination services, drop-in clinics or their GP practice.

**Healthcare professionals** (such as midwives) check the pregnant woman’s eligibility for vaccinations. They identify and discuss any concerns the pregnant woman has, using information and websites to guide discussion, and obtain informed consent. They ensure that they offer flu, pertussis and COVID-19 vaccinations to eligible pregnant women at the appropriate routine antenatal appointment. They complete documentation after giving vaccination. If they cannot give the vaccination during the appointment, they signpost pregnant women to vaccination services, drop-in clinics or their GP practice.

**Commissioners** (integrated care systems) ensure that they commission antenatal services that check eligibility for vaccinations and offer them to pregnant women at routine antenatal appointments. They monitor take-up (coverage) of flu, pertussis and COVID-19 vaccination among pregnant women and monitor data relevant to inequalities. They take action to address identified inequalities and take action to improve access and uptake.

**Pregnant women** discuss with their midwife if they may need vaccinations at routine antenatal appointments. They are given the opportunity to discuss any concerns they have about vaccinations. If they are eligible for vaccinations, they are offered them at the appropriate antenatal appointment or they are referred to a service that can give them vaccinations.

## Source guidance

* [Vaccine uptake in the general population. NICE guideline NG218](https://www.nice.org.uk/guidance/ng218) (2022), recommendations 1.2.9, 1.2.17 and 1.3.15.
* [Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201/) (2021), recommendation 1.3.8.
* [Flu vaccination: increasing uptake. NICE guideline NG103](https://www.nice.org.uk/guidance/ng103/) (2018), recommendations 1.2.3, 1.3.1, 1.4.8 and 1.4.9.

## Definitions of terms used in this quality statement

### Vaccinations during pregnancy

Pregnant women can have the following vaccinations through the following NHS programmes:

* Seasonal flu vaccination (as part of the selective immunisation programme for pregnant women). See [chapter 19 of the UK Health Security Agency’s Green Book](https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19) for full details.
* Pertussis (as part of the selective immunisation programme for pregnant women). See [chapter 24 of the UK Health Security Agency’s Green Book](https://www.gov.uk/government/publications/pertussis-the-green-book-chapter-24) for full details.
* COVID-19 (recommended in pregnancy). See [chapter 14a of the UK Security Agency’s Green Book](https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a) for full details.

The NHS summary care record, or any other available vaccination records (including records held by the person), enables opportunistic identification of pregnant women who are eligible for vaccination in their current pregnancy.

Unless the pregnant woman has a documented (or reliable verbal) vaccine history, it should be assumed that they are not immunised. A full course of immunisation should be planned, following the [UK Health Security Agency’s 2022 guidance on vaccination of individuals with uncertain or incomplete immunisation status](https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status).

Also refer to the [UK Health Security Agency's information for healthcare practitioners on the vaccination programmes for pertussis](https://www.gov.uk/government/publications/vaccination-against-pertussis-whooping-cough-for-pregnant-women/pertussis-whooping-cough-vaccination-programme-for-pregnant-women) and [flu](https://www.gov.uk/government/publications/flu-vaccination-programme-information-for-healthcare-practitioners).

[Adapted from [chapter 11 of the UK Health Security Agency’s Green Book](https://www.gov.uk/government/publications/immunisation-schedule-the-green-book-chapter-11) and [NICE’s guideline on vaccination uptake in the general population](https://www.nice.org.uk/guidance/ng218), recommendations 1.2.11 and 1.2.12].

## Equality and diversity considerations

Pregnant women should be given information that they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. Pregnant women should have access to interpreters, link worker or advocate if needed. Interpreters, link workers or advocates should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

It is important for providers to make reasonable adjustments to support pregnant women with a physical, sensory, cognitive or learning disability. For example, independent British Sign Language interpreting services may be needed. Healthcare professionals may need to plan longer appointments to enable pregnant women (and her partner, if applicable) to raise concerns, confirm correct understanding of information given and how it relates to them, and to ask questions.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

[Adapted from [NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), recommendation 1.1.1; [NICE’s guideline on pregnancy and complex social factors](https://www.nice.org.uk/guidance/cg110/), recommendations 1.3.10 and 1.3.11; and [NICE's guideline on vaccine uptake in the general population,](https://www.nice.org.uk/guidance/ng218) recommendation 1.3.4]

# Quality statement 5: Referral for stop-smoking support

## Quality statement

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

## Rationale

Stopping smoking in pregnancy is important for the health of the woman and baby. Referring partners who smoke to stop-smoking support reflects the need to reduce or prevent the mother and baby’s exposure to second-hand tobacco smoke as part of their antenatal care.

## Quality measures

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

### Process

a) Proportion of pregnant women who smoke who were given an opt-out referral for stop-smoking support at the booking appointment.

Numerator – the number in the denominator who were given an opt-out referral for stop-smoking support.

Denominator – the number of pregnant women recorded as current smokers at the booking appointment.

**Data source:** No routinely collected national data has been identified for this measure. Data can be collected from information recorded locally, for example, antenatal care records.

b) Proportion of pregnant women who smoke who were given an opt-out referral for stop-smoking support at the routine 16, 25- and 36-week antenatal appointments.

Numerator - The number in the denominator who were given an opt-out referral for stop-smoking support at the routine 16-, 25- and 36-week antenatal appointments.

Denominator - The number of pregnant women recorded as current smokers at the routine 16-, 25- and 36-week antenatal appointments who have not already engaged with stop-smoking support.

**Data source:** No routinely collected national data has been identified for this measure. Data can be collected from information recorded locally, for example, antenatal care records.

c) Proportion of pregnant women whose partner was given a referral for stop-smoking support at the booking appointment.

Numerator – the number in the denominator whose partner was given a referral for stop-smoking support.

Denominator – the number of pregnant women whose partner was recorded as a current smoker at the booking appointment.

**Data source:** No routinely collected national data has been identified for this measure. Data can be collected from information recorded locally, for example, antenatal care records.

d) Proportion of pregnant women whose partner was given a referral for stop-smoking support at the 16-, 25- and 36-week routine antenatal appointments.

Numerator – the number in the denominator whose partner was given a referral for stop-smoking support.

Denominator – the number of pregnant women whose partner was recorded as a current smoker at the 16- 25- and 36-week routine antenatal appointments.

**Data source:** No routinely collected national data has been identified for this measure. Data can be collected from information recorded locally, for example, antenatal care records.

### Outcome

a) The proportion of women who were current smokers at delivery.

Numerator - The number in the denominator who were current smokers at delivery.

Denominator - The number of women who gave birth.

**Data source:** [NHS Digital's Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) includes smoking status at delivery and the [Maternity Services Dashboard](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) can be used to monitor performance and compare services.

b) Quit rates among partners of pregnant women.

**Data source:** No routinely collected national data has been identified for this measure. Data can be collected from information recorded locally for example, antenatal care records.

## What the quality statement means for different audiences

**Service providers** (maternity services) ensure that there are local pathways in place to refer pregnant women and partners who smoke to stop-smoking support at routine antenatal appointments. They also follow up with pregnant women who opt-out of referral to stop-smoking services. They monitor carbon monoxide (CO) levels for pregnant women at the booking and routine 36-week appointments as a minimum.

**Healthcare professionals** (midwives) are trained to assess smoking status of pregnant women and partners. At routine antenatal appointments, they provide information about the hazards of smoking when pregnant and of exposure to second-hand smoke for both mother and baby. They give pregnant women who smoke an opt-out referral to stop-smoking support services and offer a referral to partners who smoke. They monitor CO levels for pregnant women at the booking and routine 36-week appointments as a minimum.

**Commissioners** (integrated care systems) ensure that they commission maternity services that provide pregnant women who smoke with opt-out referrals to stop-smoking services and offer partners who smoke a referral to stop-smoking services. They monitor rates of referrals, quit rates and smoking at delivery. They commission services which monitor CO levels for pregnant women at the booking and 36-week appointments as a minimum.

**Pregnant women** are given an automatic referral (which can be declined) for stop-smoking support at their antenatal appointments so that they can have support to reduce or stop smoking. If they have a partner who smokes, they are also offered a referral to a stop-smoking service.

## Source guidance

[Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209](https://www.nice.org.uk/guidance/ng209) (2021), recommendation 1.18.2

[Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201/) (2021), recommendations 1.2.4 and 1.3.9.

## Definitions of terms used in this quality statement

### Pregnant women who smoke

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.

[[NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209), recommendation 1.18.2]

### Partners who smoke

Partners of pregnant women who say they smoke or have stopped smoking in the past 2 weeks.

[[NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), recommendations 1.2.4]

### Referral

When a pregnant woman who smokes is identified, an automatic referral is made to specialist stop-smoking support via an opt-out referral system. This is known as an ‘opt-out referral’. The offer can be refused by the pregnant woman.

[adapted from [NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209), evidence review H].

Partners of pregnant women who smoke are offered referral 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, the pregnant woman should be asked to suggest that their partner contacts stop-smoking support using contact details provided by the healthcare professional.

[adapted from [NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209/), recommendation 1.11.10]

### Stop-smoking support

Interventions and support to stop smoking, regardless of how services are commissioned or set up.

The support may include:

### For pregnant women

* Intensive and ongoing behavioural support.
* Licensed nicotine replacement therapy (NRT) alongside behavioural support (see the [BNF information on NRT](https://bnf.nice.org.uk/drugs/nicotine/)). Note that bupropion and varenicline should not be offered to pregnant or breastfeeding women. The evidence review for [NICE’s guideline on tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209) found no evidence about the effectiveness or safety of using nicotine-containing e‑cigarettes to help women stop smoking in pregnancy.
* Voucher incentives (these may be offered jointly to a friend or family member chosen by the pregnant woman to support her during her quit attempt).

### For their partners

An intervention that comprises 3 or more elements and multiple contacts, as agreed with the person, which may include:

* Behavioural interventions (individual and group behavioural support)
* Medicinally licensed products: bupropion (see [BNF information on bupropion hydrochloride](https://bnf.nice.org.uk/drug/bupropion-hydrochloride.html)), nicotine replacement therapy (short and long acting) or varenicline (see [NICE's technology appraisal guidance on varenicline for smoking cessation](https://www.nice.org.uk/guidance/ta123). In August 2022, varenicline was unavailable in the UK. See the [MHRA alert on varenicline](https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103160))
* Nicotine-containing e-cigarettes
* Allen Carr's Easyway in-person group seminar

[Adapted from [NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence,](https://www.nice.org.uk/guidance/ng209) recommendations 1.12.1, 1.12.2, 1.12.5, 1.12.7, 1.20.1, 1.20.6, 1.20.7, 1.20.11, 1.20.12, 1.20.13, 1.20.14, 1.20.18 and terms used in that guideline]

### Routine antenatal appointments

All pregnant women are offered the booking appointment (by 10 weeks), and appointments at 16, 28, 34, 36, 38 and, for those who have not yet given birth, 41 weeks. Pregnant women who have not given birth before have 3 additional appointments, at 25, 31 and 40 weeks.

[Adapted from [NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/), recommendations 1.1.7 and 1.1.8 and schedule of antenatal appointments]

# Update information

**August 2022:** This quality standard was updated and statements prioritised in 2012 were replaced. The topic was identified for update following the annual review of quality standards. The review identified:

* changes in the priority areas for improvement
* updated guidance on antenatal care.

Statements are marked as:

* **[new 2022]** if the statement covers a new area for quality improvement
* **[2012, updated 2022]** if the statement covers an area for quality improvement included in the 2012 quality standard and has been updated.

# About this quality standard

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

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

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10155/documents).

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

* [resource impact summary report for NICE’s guideline on vaccine uptake in the general population](https://www.nice.org.uk/guidance/ng218/resources)
* [resource impact report for NICE’s guideline on tobacco](https://www.nice.org.uk/guidance/ng209/resources)
* [resource impact statement for NICE’s guideline on antenatal care](https://www.nice.org.uk/guidance/ng201/resources).

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10155/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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