NICE National Institute for Health and Care Excellence

NICE quality standard

Antenatal care

Quality standard

Published: 17 September 2012
www.nice.org.uk/guidance/qs22

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This standard is based on CG110, NG201, NG209, NG218 and NG103.

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

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In 2023 this quality standard was updated, and statements prioritised in 2012 were updated (2012, updated 2023) or replaced (new 2023). For more information, see update information.

The previous version of the quality standard for antenatal care is available as a pdf.

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Quality statement 1: Access to antenatal care

Quality statement

Pregnant women are supported to access antenatal care by 10 weeks of pregnancy. **[2012, updated 2023]**

Rationale

Supporting women to attend their first antenatal ('booking') appointment by 10 weeks of pregnancy will enable early identification of potential risks and ensure that care is planned according to their 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. All women who present after 10 weeks of pregnancy should be supported to access antenatal care as soon as possible. Some pregnant women and their babies have a higher risk of adverse outcomes or have complex social factors and may need additional support to access 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 booking appointments held by 10 weeks of pregnancy.

Numerator – the number in the denominator held by 10 weeks of pregnancy.

Denominator – the number of booking appointments.

Data source: NHS Digital's Maternity Services Data Set includes gestational age at the

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booking appointment and the NHS Digital's Maternity Services dashboard can be used to monitor performance and compare services.

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 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. 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 for ongoing audit. The NHS Digital 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 also ensure that a booking appointment can be arranged as soon as possible for women who access antenatal care after 10 weeks. They provide accessible information about pregnancy and antenatal care services, and a variety of options for women to start their antenatal care. Providers ensure that healthcare professionals have the skills and knowledge they need to support women who have a high risk of adverse outcomes or who have complex social factors to access antenatal care.

GPs and allied health professionals support and encourage pregnant women who want to continue the pregnancy to access antenatal care by discussing the need for antenatal care with them. They tell women that their partner can be involved according to her wishes,

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highlighting that it is her choice.

Midwives offer a booking appointment in the first trimester, ideally within 10 weeks of pregnancy. They offer women who access antenatal care after 10 weeks of pregnancy a booking appointment as soon as possible.

Commissioners (integrated care systems) ensure that they commission antenatal care services which pregnant women can access easily by 10 weeks of pregnancy. They ensure that services arrange a booking appointment as soon as possible for pregnant women who present late. Commissioners work with providers to use data and intelligence to improve access to antenatal care by 10 weeks for pregnant women with a higher risk of adverse outcomes. This includes pregnant women:

- from Black, Asian (excluding Chinese), and mixed ethnic family backgrounds
- living in the most deprived areas
- with 1 or more complex social factors
- who access antenatal care late.

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. They can get a first appointment quickly if they access antenatal care after 10 weeks of pregnancy. Pregnant women can involve their partner (if applicable) in their antenatal care if they wish and can invite them to attend the booking appointment.

Source guidance

- Antenatal care. NICE guideline 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 (2010), recommendations 1.1.11, 1.3.1 and 1.3.5

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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).

Those responsible for the organisation of local antenatal services should provide information about pregnancy and antenatal services, including how to find and use them. The information can be presented in a variety of settings (such as pharmacies, children's centres, reception centres and hostels) and languages

It should be clear that an interpreter can be provided when needed. [Adapted from NICE's guideline on antenatal care, recommendations 1.1.1 and 1.1.2 and NICE's guideline on pregnancy and complex social factors, recommendations 1.3.5 and 1.3.10]

Equality and diversity considerations

To encourage uptake of antenatal care services by women in vulnerable groups and who have additional protected characteristics healthcare professionals should:

- offer age-appropriate services in the community
- use a variety of means to communicate (for example, text messages) to remind women of upcoming and missed antenatal appointments)
- provide information about help with transportation to and from appointments.

Service providers should ensure that digital access to antenatal care does not prevent women who do not have IT literacy or access to IT equipment from accessing antenatal care and that additional support is available if needed. They should ensure that a choice of a digital or face-to-face appointment is offered, taking into account the woman's clinical needs and preferences, including those arising from disability or sensory loss. The physical environment of the clinic room may need to be adjusted to take account of additional needs (for example, lighting). [Adapted from NICE's guideline on pregnancy and complex social factors, recommendations 1.2.8, 1.2.11, 1.3.1 and 1.4.1 and expert opinion]

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For pregnant women (and if applicable, their partner) with additional needs related to a disability (including those arising from neurodiversity), impairment or sensory loss, information and referral forms should be provided as set out in the NHS Accessible Information Standard, or the equivalent standards for the devolved nations. This is to help them understand information about accessing antenatal services and how to use them. Some pregnant women with additional needs may need longer antenatal appointments.

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Quality statement 2: Risk assessment

Quality statement

Pregnant women have a risk assessment at routine antenatal appointments. **[2012, updated 2023]**

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, genetic, 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. NHS Digital's Maternity Services Data Set includes recording risk factors such as obstetric history, medical (including mental health) history and social history. Recording risk factors at the booking appointment also supports the NHS England Saving Babies' Lives Care

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Bundle.

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.

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. The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity 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. Trusts report on stillbirth rates as part of reporting on perinatal mortality rates using the MBRRACE-UK-National Perinatal Mortality Review Tool for ongoing audit. NHS Digital's Maternity Services Data Set includes data on stillbirths and the NHS Digital 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. Trusts report on neonatal mortality as part of reporting on perinatal mortality rates using the MBRRACE-UK-National Perinatal Mortality Review Tool for ongoing audit. NHS Digital's Maternity Services Data Set includes data on neonatal mortality and the NHS Digital

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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 and that time is allocated for this to be done. 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. Healthcare professionals involve the woman's partner according to her wishes.

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 (2021), recommendation 1.2.10

Definitions of terms used in this quality statement

Risk assessment

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

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- ask the woman about her general health and wellbeing including risk factors for venous thromboembolism, gestational diabetes, pre-eclampsia and fetal growth restriction
- ask the woman (and her partner, if present) if there are any concerns they would like to discuss; this could include discussing risks relating to parental genetic conditions, including consanguinity, and factors relevant to the environment in which she lives, at the booking appointment
- 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, previous traumatic birth) or mental health concerns
- review and reassess the plan of care for the pregnancy
- identify women who need additional care.

The assessment should recognise that women's needs can change during pregnancy. It should be broad-based and holistic, aiming to recognise if 1 or more elements of the woman's physical and mental health (taking into account her medical history) and wellbeing represents a risk to her or her baby's health or wellbeing.

It is important, after discussion and agreement with the woman, that information about the pregnancy and potential concerns or complications during pregnancy are shared between the maternity unit and the woman's GP. [NICE's guideline on antenatal care, recommendations 1.2.9, 1.2.10, 1.2.18, 1.2.21, 1.2.23, 1.2.29 and expert opinion]

Routine antenatal appointments

All pregnant women are offered the booking appointment (by 10 weeks), and appointments at 16, 28, 34, 36 and 38 weeks, and 41 weeks (for those who have not yet given birth). 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, 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 highlight that pregnant women and babies from Black, Asian, and mixed ethnic family backgrounds and those who live in

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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 an interpreter, 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 their partner, if applicable) 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, recommendations 1.1.11 and 1.3.6 and NICE's guideline on pregnancy and complex social factors, recommendations 1.3.10 and 1.3.11].

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Quality statement 3: Continuity of carer

Quality statement

Pregnant women have coordinated care from a small team of midwives. **[2012, updated 2023]**

Rationale

A small team of midwives (about 4 to 8 individuals), working with other healthcare professionals throughout pregnancy, can ensure that the needs of the pregnant woman and her baby are met. This team is the main point of contact, coordinating care and sharing information with one another and other healthcare professionals. This helps to ensure consistency of midwifery input and safer, more personalised and responsive maternity care. It should only be implemented if local maternity systems have identified they can fulfil safe minimum staffing requirements. Providing coordinated care during pregnancy supports the NHS national programme of continuity of carer.

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. Achievement will be dependent on the ability of local services to fulfil safe minimum staffing requirements.

Process

The proportion of pregnant women who received care from a small team of midwives throughout their pregnancy.

Numerator – The number in the denominator who received care from a small team of midwives throughout their pregnancy.

Denominator – The number of pregnant women.

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Data source: Data can be collected from information recorded locally such as antenatal care records. NHS Digital's Maternity Services Data Set includes placement on the continuity of carer pathway and the NHS Digital Maternity Services dashboard shows monthly data on the proportion of women on continuity of carer pathways, including at trust level.

Outcome

The proportion of women who gave birth who said they saw or spoke to members of the same team of midwives at antenatal appointments.

Numerator – the number in the denominator who said they saw or spoke to members of the same team of midwives every time at antenatal appointments.

Denominator – the number of women who gave birth.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient experience surveys. The annual Care Quality Commission Maternity Survey collects data about women's experiences of the continuity of their antenatal care, including: At your antenatal check-ups, did you see or speak to the same midwife every time?

What the quality statement means for different audiences

Service providers (maternity services) ensure that protocols and processes are in place for women and their babies to have access to a small team of midwives. Providers monitor staffing levels to ensure it is safe to implement. 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) working in a small team, are responsible for planning consistent, individualised care for a woman and her baby during pregnancy. They communicate and share information with other midwives in the team and with other healthcare professionals in a timely and effective manner, so that any concerns about the woman or baby's health are recognised.

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Commissioners (integrated care systems) ensure that they commission services that give pregnant women access to a small team of midwives who ensure that consistent and individualised care is provided. Commissioners seek ongoing assurance that providers are monitoring staffing levels to ensure it is safe to implement. Commissioners 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 small team of midwives who they can contact and who coordinate care for her and her baby (working with one another and other healthcare professionals).

Source guidance

Antenatal care. NICE guideline NG201 (2021), recommendation 1.1.12

Definitions of terms used in this quality statement

Small team of midwives

A midwifery team (about 4 to 8 individuals) that 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 within the midwifery team and with 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, terms used in this guideline and expert opinion]

Equality and diversity considerations

Providers could consider establishing teams of midwives that specialise in caring for women who have specific needs such as complex medical or social needs.

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Quality statement 4: Vaccination

Quality statement

Pregnant women are offered vaccinations at routine antenatal appointments. **[new 2023]**

Rationale

The influenza (flu) and pertussis (whooping cough) vaccines for pregnant women are included in the NHS complete routine immunisation schedule. Chapter 14a of the UK Health Security Agency's Green Book recommends pregnant women have the COVID-19 vaccine. Offering pregnant women suitable 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 had the seasonal flu vaccination during pregnancy.

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

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

Data source:NHS Digital's Maternity Services Data Set includes data on vaccination (immunisation) carried out by maternity services. The UK Health Security Agency provides national data on seasonal flu vaccine uptake in pregnant women. Seasonal flu vaccine uptake data by GP patients by ethnicity is available for NHS commissioning regions. Take-up data for pregnant women disaggregated by ethnicity is available.

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

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

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

Data source:NHS Digital's 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 in pregnant women in England by local teams, integrated care systems, and NHS England regions. This uses information submitted by antenatal and other services offering vaccinations to pregnant women through their registration with a GP.

c) The proportion of eligible women who had a COVID-19 vaccine during pregnancy.

Numerator – the number in the denominator who had a COVID-19 vaccine during pregnancy.

Denominator – the number of pregnant women eligible for a COVID-19 vaccine.

Data source:NHS Digital's 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 which includes data on coverage among pregnant women, including the number of doses by time of delivery and the timing of administration (trimester). Take-up data disaggregated by ethnicity and deprivation quintile are available.

Outcome

a) Rates of hospitalisation and intensive care unit admission in pregnant women because

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of 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, which forms part of the UK Health Security Agency's surveillance of influenza and other seasonal respiratory viruses (and from the 2020 to 2021 season, COVID-19). Data disaggregated by age ranges and region are available.

b) Incidence of pertussis.

Data source: The UK Health Security Agency provides quarterly and annual statistics 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 because of 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, which forms part of the UK Health Security Agency's surveillance of influenza and other seasonal respiratory viruses (and from the 2020 to 2021 season, COVID-19). Data disaggregated by age ranges, sex, ethnicity and region are available. Experimental statistics on the incidence of COVID-19 hospital admissions (per 100,000 infections) by pregnancy and vaccination status are available from the Office for National Statistics.

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. This is in line with Public Health England's national minimum standards and core curriculum for immunisation training for registered healthcare practitioners. 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

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their GP practice.

Healthcare professionals (such as midwives) check the pregnant woman's eligibility for vaccinations and provide evidence-based, consistent information about vaccinations. Healthcare professionals 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. Commissioners monitor take-up (coverage) of flu, pertussis and COVID-19 vaccination among pregnant women and monitor data relevant to health inequalities. They take action to address identified inequalities and improve access and uptake.

Pregnant women have a discussion with their midwife at routine antenatal appointments about any vaccinations they may need. 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 (2022), recommendations 1.2.9, 1.2.17 and 1.3.15
- Antenatal care. NICE guideline NG201 (2021), recommendation 1.3.8
- Flu vaccination: increasing uptake. NICE guideline NG103 (2018), recommendations 1.2.3, 1.3.1, 1.4.8 and 1.4.9

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Definitions of terms used in this quality statement

Vaccinations during pregnancy

For details of the vaccinations which pregnant women can have, see the UK Health Security Agency's Green Book and the NHS complete routine immunisation schedule.

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 an interpreter, 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 or the equivalent standards for the devolved nations.

Services should ensure that healthcare professionals have access to resources and training which enable them to develop cultural sensitivity to help address variation in uptake of vaccination by women from different ethnic family backgrounds. [Adapted from NICE's guideline on antenatal care, recommendation 1.1.1; NICE's guideline on pregnancy and complex social factors, recommendations 1.3.10 and 1.3.11; NICE's guideline on vaccine uptake in the general population, recommendation 1.3.4 and expert opinion]

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Quality statement 5: Referral for stop-smoking support and treatment

Quality statement

Pregnant women and partners who smoke are referred for stop-smoking support and treatment at routine antenatal appointments. **[2012, updated 2023]**

Rationale

Stopping smoking in pregnancy is important for the health of the woman and baby. Referring partners who smoke for stop-smoking support and treatment reflects the need to reduce or prevent the mother and baby's exposure to second-hand tobacco smoke as part of their antenatal care. In support of NHS England's Saving Babies' Lives Care Bundle, identifying women and their partners who smoke at routine antenatal appointments enables those who have not engaged with specialist support or who have relapsed to be identified and re-referred for stop-smoking support and treatment.

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 booking appointments that included a carbon monoxide (CO) test.

Numerator – the number in the denominator that included a CO test.

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. NHS

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Digital's Maternity Services Data Set includes data for CO measurement readings at the booking appointment, which supports the NHS England Saving Babies' Lives Care Bundle.

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

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

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. NHS Digital's Maternity Services Data Set collects data on smoking status at the booking appointment. The proportion of women who are recorded as smokers at the booking appointment is displayed on the NHS Digital Maternity Services dashboard, enabling data to be compared for services.

c) Proportion of pregnant women whose partner was recorded as a current smoker and was given a referral for stop-smoking support and treatment at the booking appointment.

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

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 36-week routine antenatal appointments that included a CO test.

Numerator – the number in the denominator that included a CO test.

Denominator – the number of 36-week routine antenatal appointments.

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Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records. NHS Digital's Maternity Services Data Set includes data for CO measurement readings at the 36-week appointment which supports the NHS England Saving Babies' Lives Care Bundle.

e) Proportion of pregnant women who smoke who were given an opt-out referral for stop-smoking support and treatment at the 36-week routine antenatal appointment.

Numerator – The number in the denominator who were given an opt-out referral for stop-smoking support and treatment at the 36-week routine antenatal appointment.

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

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.

f) Proportion of pregnant women whose partner was recorded as a current smoker and was given a referral for stop-smoking support and treatment at the 36-week routine antenatal appointment.

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

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

Outcome

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

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

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Denominator – the number of women who gave birth.

Data source:NHS Digital's Maternity Services Data Set includes smoking status at delivery, and also collects demographic data including index of multiple deprivation. The NHS Digital Maternity Services dashboard can be used to monitor performance and compare services.

b) The proportion of pregnant women with a partner who was a current smoker at delivery.

Numerator – the number in the denominator whose partner was a current smoker at delivery.

Denominator – the number of pregnant women who gave birth who have a partner.

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 equipment is available to monitor CO levels in pregnant women. They provide training to midwives on assessing the smoking status of pregnant women and partners. They ensure that local pathways are in place to refer pregnant women and partners who smoke for stop-smoking support and treatment.

Healthcare professionals (midwives) assess the 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 the pregnant woman and her baby. They provide pregnant women who smoke with an opt-out referral for stop-smoking support and treatment and offer a referral to partners who smoke. They monitor CO levels in pregnant women at the booking and other routine antenatal appointments.

Commissioners (integrated care systems) ensure that they commission maternity services that provide pregnant women who smoke with opt-out referrals for stop-smoking support and treatment and offer partners who smoke a referral for stop-smoking support and

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treatment. They monitor rates of referrals, quit rates and smoking at delivery. They commission services which monitor CO levels in pregnant women at the booking and other routine antenatal appointments.

Pregnant women who smoke are given an automatic referral (which can be declined) for stop-smoking support and treatment 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 for stop-smoking support and treatment.

Source guidance

Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline NG209 (2021, updated 2023), recommendations 1.18.1 and 1.18.2

Antenatal care. NICE guideline 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 CO 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 and treatment.

[NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence, 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, recommendation 1.2.4]

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Referral

When a pregnant woman who smokes is identified, an automatic referral is made for specialist stop-smoking support and treatment via an opt-out referral system. This is known as an 'opt-out referral'. The referral can be refused by the pregnant woman. [Adapted from NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence, evidence review H].

Partners of pregnant women who smoke are offered referral to a hospital or local stop-smoking support and treatment (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 and treatment using contact details provided by the healthcare professional. [Adapted from NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence, recommendation 1.11.10]

Stop-smoking support and treatment

For pregnant women

Please see NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence, recommendations 1.20.1 to 1.20.17.

For their partners

Please see NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence, section 1.12 and recommendation 1.20.18.

Routine antenatal appointments

All pregnant women are offered the booking appointment (by 10 weeks), and appointments at 16, 28, 34, 36 and 38 weeks, and 41 weeks (for those who have not yet given birth). 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, recommendations 1.1.7 and 1.1.8 and schedule of antenatal appointments]

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Update information

February 2023: 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 2023]** if the statement covers a new area for quality improvement
- **[2012, updated 2023]** if the statement covers an area for quality improvement included in the 2012 quality standard and has been updated.

The previous version of the quality standard for antenatal care is available as a pdf.

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About this quality standard

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

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

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

See our webpage on quality standards advisory committees 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.

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

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

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

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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
- resource impact report for NICE's guideline on tobacco
- resource impact statement for NICE's guideline on antenatal care
- resource impact report for NICE's guideline on flu vaccination.

Diversity, equality and language

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

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

ISBN: 978-1-4731-5024-9

Endorsing organisation

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

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