NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE quality standards

Equality impact assessment

Antenatal care (update)

The impact on equality has been assessed during quality standard development according to the principles of the NICE equality policy.

### 1. TOPIC ENGAGEMENT STAGE

### 1.1 Have any potential equality issues been identified during this stage of the development process?

The topic overview for the quality standard makes it clear that the terms 'woman' and ‘mother’ should be taken to include people who do not identify as women but who are pregnant.

[NICE’s updated antenatal care guideline (NG201)](https://www.nice.org.uk/guidance/ng201) recommends that additional or longer antenatal appointments are offered if needed, depending on the woman's medical, social and emotional needs.

Women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring and additional support.

Risk assessment of pregnant women’s mental health is a significant issue. Almost a quarter of all deaths of women during pregnancy or up to a year after the end of pregnancy were from mental health-related causes. Maternal suicide remains the leading cause of direct (pregnancy-related) death occurring within a year after the end of pregnancy ([MBRRACE-UK, confidential enquiry into Maternal Deaths in the UK and Ireland](https://www.npeu.ox.ac.uk/mbrrace-uk/reports/), report for 2021). Cardiovascular disease is the leading cause of death among women in the UK during and after pregnancy. The guideline recommends that if there is a concern based on personal or family history, that the pregnant woman is referred for clinical assessment by a doctor to detect cardiac conditions. Assessment of pregnant women with heart disease or cardiovascular risk during pregnancy and the intrapartum period is covered by statement 3 of [NICE’s quality standard on intrapartum care: existing medical conditions and obstetric complications](https://www.nice.org.uk/guidance/qs192).

Pregnant women with learning disabilities have poorer maternal wellbeing and pregnancy outcomes in relation to the general population, and are also less likely to seek or attend regular antenatal care (The Office for Health Improvement and Disparities (2021), [Antenatal and newborn screening: reducing inequalities](https://www.gov.uk/government/publications/antenatal-and-newborn-screening-identifying-and-reducing-inequalities/annb-screening-reducing-inequalities): supporting pregnant women with learning disabilities).

The guideline recommends specific adjustments for women with physical, sensory, cognitive, neurological or cognitive disabilities:

* early pregnancy information (provided at the point of referral) should be available in different formats, including braille and Easy Read.
* reliable British Sign Language interpretation, which is independent of the woman rather than using a family or friend, should be provided when needed for antenatal appointments (highlighted as MBRRACE-UK Confidential Enquiry in Maternal Deaths, 2021 report).

The guideline highlights that reliable interpreting services should be provided when needed to women who have difficulty speaking or reading English. The guideline also cross-references to the [NICE guideline on pregnancy and complex social factors](https://www.nice.org.uk/guidance/cg110) regarding further support for women who have difficulty speaking or reading English, women who misuse substances, recent migrants, asylum seekers or refugees, young women aged under 20 and women who experience domestic abuse. Complex social factors are recorded at the booking appointment and recorded as part of [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/tools-and-guidance).

The guideline recommends that each antenatal appointment should provide a safe environment and opportunities for the woman to discuss domestic abuse, concerns about the birth (for example, if she previously had a traumatic birth) or mental health concerns as part of a risk assessment.

The rationale and impact section of recommendation 1.1.16 highlights that remote (virtual) appointments could disadvantage, for example, people who have sensory disabilities, have difficulty reading or speaking English, some minority groups, or in relation to access to devices or internet connection. Potential inequalities issues that could be associated with video appointments, for example should be carefully considered.

These issues will be considered as the quality standard update is developed.

### 1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

Women who are over 42 weeks pregnant are excluded because this population is covered by quality standards on [inducing labour](https://www.nice.org.uk/guidance/qs60), [intrapartum care](https://www.nice.org.uk/guidance/qs105) and [postnatal care](https://www.nice.org.uk/guidance/qs37)

Treatment, care and management (beyond identification and referral) of specific physical conditions, mental health conditions and antenatal complications are excluded from the quality standard. These are covered by other quality standards: [diabetes in pregnancy](https://www.nice.org.uk/guidance/qs109) (update of the published quality standard,[QS109](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).

Completed by lead technical analyst: Rachel Gick

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### 2. PRE-CONSULTATION STAGE

### 2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed?

The overview section of the quality standard makes clear that the terms 'woman' and ‘mother’ should be taken to include people who do not identify as women but who are pregnant.

During topic engagement stakeholders highlighted the following issues, which were discussed by the committee:

* The need to ensure visibility of maternity services in local communities. Migrant women, women who are refugees and women who are asylum seekers were identified as priority groups to encourage access antenatal care.
* The increased risk of death among mothers and babies of black, Asian (excluding Chinese) and mixed ethnic backgrounds, and among women and babies living in the most deprived, compared to white women and babies, and women living in the least deprived backgrounds.
* The need to support pregnant women with neurodevelopmental conditions to access antenatal care services was highlighted.
* The need to improve access to antenatal care for trans and non-binary people who are pregnant.

The committee agreed to update statement 1 in [NICE’s quality standard on antenatal care QS22](https://www.nice.org.uk/Guidance/QS22), but amend this to highlight that the focus is now on women accessing antenatal care (the first ‘booking’ antenatal appointment) by 10 weeks of pregnancy. The commissioner audience descriptor highlights that commissioners should work with providers to use data and intelligence to improve access to antenatal care by 10 weeks of pregnancy for pregnant women at a greater risk of adverse outcomes. This includes women from minority ethnic backgrounds, pregnant women living in the most deprived areas, and pregnant women with 1 or more complex social factors.

Disaggregating data by ethnicity, other protected characteristics, deprivation, complex social factors (as recommended by [NICE’s guideline on pregnancy and complex social factors CG110](https://www.nice.org.uk/Guidance/CG110)), and by vulnerable groups would enable local health systems to monitor take-up of early antenatal care by different groups, which includes trans and non-binary people.

The equality and diversity section of the statement highlights actions that healthcare professionals can take to encourage uptake of antenatal care services among women in protected characteristic and vulnerable groups.

The updated statement 1 also highlights that antenatal care services need to provide information about pregnancy, services, and how to use them, in a range of local settings, formats and languages. The information should cover entitlement to healthcare services because pregnant women who are migrants, refugees or asylum seekers are likely to be unfamiliar with UK healthcare services, and move between locations. The need for services to ensure that healthcare professionals have the skills and knowledge they need to support women with complex social factors access antenatal care is noted, and includes knowledge of the latest policies on entitlement to healthcare.

The committee agreed to update statement 2 (‘continuity of care’) in the current antenatal care quality standard which concerns women having a named midwife to provide continuity of carer during pregnancy. Stakeholders highlighted that pregnant women benefit from tailored care from specialist teams of midwives who specialise in caring for specific groups of women such as women with medically complex pregnancies, women from minority ethnic backgrounds and women needing socially complex care as part of the ongoing national roll-out of midwifery continuity of carer.

The updated statement, which appears as statement 3 in the updated quality standard, supports the anticipated completion of national implementation of this care model to all women (subject to any decisions following [the final report of the Ockenden review, published in 2022](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review)). The committee noted that [NHS England’s 2022/23 priorities and operational planning guidance](https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/) highlights that data presented to integrated care boards, and trust performance packs, should be disaggregated by ethnicity and deprivation.

Statements 2 and 4 concern aspects of care where effective communication between healthcare professionals and the pregnant woman (and her partner) is a focus. Statement 2 concerns including formal risk assessment at each antenatal appointment, highlighting the need to identify women needing referral for further assessment and management. Stakeholders highlighted that heart disease and VTE remain the leading causes of indirect and direct (pregnancy-related) maternal death respectively ([MBRRACE-UK reports on maternal mortality](https://www.npeu.ox.ac.uk/mbrrace-uk)). Statement 4 (a new area) concerns healthcare professionals offering - supported by information, discussion and consent - vaccinations recommended during pregnancy at antenatal appointments.

The equality and diversity sections of both statements highlight ‘reasonable adjustment’ that providers should make to the delivery of care so that pregnant women (and their partner) who have difficulty communicating, reading or speaking English or have a physical, sensory or learning disability can fully participate. The following adjustments were highlighted by stakeholders and have been included as equality and diversity considerations:

* high-quality interpreting and translation services are essential to communicate effectively with women who are deaf and women for whom English is not their first language.
* The need to support pregnant women with conditions and cognitive disabilities to participate.

Further, the equality and diversity section for both statements highlight the need for longer appointments to support people with a physical, sensory or learning disability to communicate effectively with healthcare professionals. This section in statement 4 reflects that it is recommended in the underpinning NICE guideline that information about vaccination is used to inform discussion. The text consequently also refers to the information being provided in formats in line with the [NHS’s Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/) (or equivalent standard in the devolved nations).

The committee agreed to update the existing statement 5 in QS22. This is also statement 5 in the updated quality standard. Stakeholders highlighted that rates of smoking vary within certain equality groups and that comorbidities (including diabetes and high blood pressure) in pregnant women who smoke would need to be considered when tailoring information and support. Stakeholders highlighted the association of higher rates of smoking in pregnancy with deprivation, and that a higher rate of white women smoked at delivery.

The updated statement does not focus on giving brief advice so tailoring information is not relevant. It focuses on pregnant women who smoke (or have stopped smoking within 2 weeks) and their partner, if they smoke, being referred for stop-smoking support. Retaining and updating this statement supports national work in this area. Reducing smoking during pregnancy is also an element in the [NHS’s Saving babies’ lives care bundle](https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/) and [NHS England’s 2021 Equity and equality guidance for local maternity systems](https://www.england.nhs.uk/publication/equity-and-equality-guidance-for-local-maternity-systems/). Reducing smoking during pregnancy had already been identified a priority area as part of the update of NICE’s quality standards on smoking: supporting people to stop (QS43) and smoking: harm reduction (QS92). Data to support process measures is to be collected at local level.

Stakeholders suggested that health inequalities for at risk populations should be included for women with gestational or pre-existing diabetes in the equality impact assessment for the updated quality standard on antenatal care. The committee agreed that additional care for women with diabetes in pregnancy is covered by NICE’s quality standard on diabetes in pregnancy (QS109) – update in development.

### 2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues?

No changes have been made to the scope of the quality standard at this stage.

### 2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

None of the quality statements make it difficult for a specific group to access services.

### 2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

None of the quality statements have an adverse impact on people with disabilities.

### 2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE’s obligation to advance equality?

No additional recommendations or explanations have been identified at this stage.

Completed by lead technical analyst: Rachel Gick

Date: 02/08/2022

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Date: 09/08/2022

### 3. POST-CONSULTATION STAGE

### 3.1 Have any additional potential equality issues been raised during the consultation stage, and, if so, how has the committee addressed them?

Stakeholders noted and supported that the draft quality standard has a strong focus on inequalities in outcomes for different groups. They also highlighted:

* women known to social services should be included in the quality standard.
* adjusting the way care is delivered to meet the additional communication needs of pregnant women with fetal alcohol syndrome disorder and other neurodevelopmental conditions was raised as a particular concern.
* stakeholders noted the importance of healthcare professionals receiving training to support pregnant women who have differing levels of health literacy.

In relation to individual statements, stakeholders suggested:

* 2: They also suggested that pregnant women with post-traumatic syndrome disorder may need longer appointments.
* 3: Stakeholders felt that consideration may be given to teams of midwives delivering ‘continuity of carer’ to specific cohorts of women, including women from Black, Asian and mixed ethnic family backgrounds.
* 5: Stakeholders commented that rates of smoking vary according to deprivation, ethnicity, religion, sexual orientation and country of birth.

The committee additionally identified:

* To support early access to antenatal services and support informed decision making, information should be provided in multiple formats and meet the [Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) (statement 1).
* Information about antenatal care should be inclusive of gender fluidity to encourage to access and take-up of antenatal care by trans and non-binary people who are pregnant (statement 1).
* The need to convey information about vaccinations (statement 4) to support uptake by women from different ethnic family backgrounds was highlighted. ‘Cultural sensitivity’ was preferred to ‘cultural competence’.

These points were discussed by the committee. The following amendments were made to the statements:

* Statement 1:
  + The equality and diversity section highlights the need to provide materials supporting access to antenatal care services in a range of formats to meet a range of communication needs. These include providing materials in Easy Read to support people additional communication needs, including those arising from neurodiversity, and notes that not all needs are covered by the scope of the [NHS Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/). The need for longer appointments to support additional needs is also noted.
  + The equality and diversity section also highlights that 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. It also highlights that a choice between a digital and in-person appointment should be offered, taking account of clinical needs and preferences, including additional needs arising from a disability and that the physical environment of the clinic room is adjusted to take account of additional needs.
* Statement 2: The definition of ‘risk assessment’ has been amended, to include reference to consanguinity.
* Statement 3: The equality and diversity section notes highlights that providers could consider establishing teams of midwives that specialise in caring for women who have specific needs such as complex medical or social needs.
* Statement 4: The equality and diversity section highlights the importance of services providing 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. This section also highlights that pregnant women should, if needed, have access to an independent interpreter.
* Statement 5: The data source for the outcome measure a), the proportion of women who were current smokers at delivery, highlights that [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) collects data on the multiple index of deprivation and other demographic information.

### 3.2 If the quality statements have changed after the consultation stage, are there any that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No changes to the quality statements make it more difficult to access services.

### 3.3 If the quality statements have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No changes to the statements have an adverse effect on people with disabilities.

### 3.4 If the quality statements have changed after consultation, are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 and 3.3, or otherwise fulfil NICE’s obligations to advance equality?

N/A

Completed by lead technical analyst: Rachel Gick

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Approved by NICE quality assurance lead: Mark Minchin

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### 4. After NICE Guidance Executive amendments

### 4.1 Outline amendments agreed by Guidance Executive below, if applicable:

No amendments requested.

Completed by lead technical analyst: Rachel Gick

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