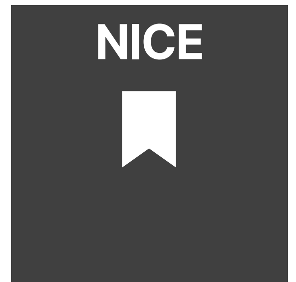
NICE National Institute for Health and Care Excellence



Resource impact statement

Resource impact
Published: 17 April 2019

Last updated: 23 August 2023

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The NICE guideline on ectopic pregnancy and miscarriage: diagnosis and initial management originally published in 2019 and was partially updated in the areas of anti-D immunoglobulin prophylaxis (June 2026), medical management of miscarriage (August 2023) and management of miscarriage (November 2021). The updates replace the relevant parts from the original guideline.

Anti-D immunoglobulin prophylaxis (June 2026 update)

The guideline update advises not to offer anti-D immunoglobulin prophylaxis to anyone with a miscarriage or ectopic pregnancy up to and including 11+6 weeks of pregnancy. The previous NICE guidance was to offer anti-D prophylaxis to those who are rhesus D negative who have a surgical procedure to manage an ectopic pregnancy or miscarriage. A further change in recommendations also means that anti-D prophylaxis can be considered in cases of threatened miscarriage with heavy and recurrent bleeding between 12+0 and 12+6 weeks of pregnancy.

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For hospitals that currently follow the previous NICE guideline, savings will be generated as they will no longer need to offer anti-D prophylaxis to anyone with a miscarriage or ectopic pregnancy up to and including 11+6 weeks of pregnancy. Treatment with anti-D prophylaxis is inexpensive, and the estimated population for those needing treatment in England is small, so any savings generated by not needing to offer anti-D prophylaxis are likely to be small. There may be a small offset to these savings by anti-D prophylaxis being considered in cases of threatened miscarriage with heavy and recurrent bleeding between 12+0 and 12+6 weeks of pregnancy. The recommendations may remove barriers from early pregnancy services being provided in community locations, such as being incorporated within a women's health hub.

Medical management of miscarriage (August 2023 update)

We expect that the resource impact of this update:

- for any single guideline recommendation in England will be less than £1 million per year (or approximately £1,800 per 100,000 population, based on a population for England of 56.6 million people) **and**
- for implementing the whole guideline in England will be less than £5 million per year (or approximately £8,800 per 100,000 population, based on a population for England of 56.6 million people).

This updated guideline recommends the use of mifepristone in combination with misoprostol for the medical management of missed miscarriage (recommendation 1.11.1). Mifepristone is currently used in early pregnancy settings, but the recommendation may increase the use of misoprostol. Any additional costs because of this increase in use should be offset by a reduction in surgical interventions.

The recommendation to provide pregnancy tests if the resolution of bleeding and pain indicate that the miscarriage has completed (recommendation 1.11.8) will increase the number of urine pregnancy tests supplied. However, the unit cost of a urine test is small.

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The updated guideline recommends changing the time a woman or person should contact their healthcare team, if bleeding has not started, from 24 hours to 48 hours (recommendation 1.11.2). This will lead to a capacity benefit. However, if there are concerns that the woman or person will not contact their healthcare team, there should be an arrangement for the service to follow up with these people, which will take additional staff time. The overall capacity impact of the recommendation is expected to be roughly neutral.

Maternity services and transitional care are commissioned by integrated care boards. Providers are NHS hospital trusts, primary care, and community care services.

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