National Institute for Health and Care Excellence

FINAL

Antenatal care

[G] Content of antenatal appointments

NICE guideline NG201

Evidence reviews underpinning recommendations 1.2.1 to 1.2.17, 1.2.23 to 1.2.25, 1.2.30, 1.3.8, 1.3.11, and 1.3.15 to 1.3.16

August 2021

Final

These evidence reviews were developed by the National Guideline Alliance, which is a part of the Royal College of Obstetricians and Gynaecologists

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive. All NICE guidance is subject to regular review and may be updated or withdrawn.

Copyright

ISBN: 978-1-4731-4227-5

Contents

Content of antenatal appointments

Review question

What should the content of antenatal appointments be?

Introduction

Pregnant women are offered antenatal appointments throughout the pregnancy to monitor the wellbeing of the woman and the baby, share information, discuss any concerns, plan for birth and prepare for the postnatal period. The routine content of each appointment depends on the phase of the pregnancy. In this report, the information and discussions underpinning the recommendations on content of antenatal appointments are documented.

Methods and process

This report was developed using the methods and process described in Developing NICE guidelines: the manual, in particular section 8 Linking to other guidance.

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Content of antenatal care appointments essentially covers what is discussed and what assessments, examinations, investigations or interventions are done during the antenatal appointments. Much of the content of antenatal appointments is already covered by other relevant sources, such as:

- other evidence reviews covered by this guideline, which were developed using the systematic reviewing methodology, including cost effectiveness and resource impact considerations
- other NICE guidelines, which were developed using the systematic reviewing methodology, including cost effectiveness and resource impact considerations
- national legislation or policy, such as guidance or programmes by the UK National Screening Committee, Joint Committee for Vaccination and Immunisation and Public Health England.

Based on the process for linking to other guidance outlined in the section 8 of the Developing NICE guidelines: the manual, the committee agreed that the issues covered by reviews in other NICE guidelines relevant for this question were similar enough, covered the topics appropriately and the evidence underpinning the recommendations is unlikely to have changed significantly since these reviews were developed. Therefore, they felt confident that it is appropriate to cross refer to these other guidelines. Similarly, they were confident that the evidence review processes underpinning the recommendations from the UK National Screening Committee and the Joint Committee for Vaccination and Immunisation were up to date and appropriate.

In addition to the content covered by these sources, the committee identified gaps which should not be missed from the recommendations so that beneficial activities would not be inadvertently lost from current usual care and so that the guideline makes sense to those implementing it. They discussed if these gaps could be addressed by consensus-based decision making without reviewing evidence. The criteria for making recommendations addressing these gaps without reviewing new evidence, via informal committee consensus to reflect best practice, was that there is no clinical uncertainty and no significant resource impact, or the potential limited resource impact could be justifiably off set by benefits down the line, such as improved outcomes, avoidance of serious adverse outcomes or addressing inequalities issues according to NICE principles. The committee generally agreed that the

identified gaps could be addressed by consensus-based decision making on current best practice. As a result, it was agreed no separate systematic review was required for this topic.

The process for developing recommendations on the content of antenatal appointments was as follows:

- The technical team with advice from the NICE quality assurance team initially used the 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content) as the basis for what the content currently is.
- The technical team then mapped out other relevant sources (such as those listed above) that cover elements of the content of antenatal appointments.
- Based on this initial mapping, the committee then met to discuss:
  - if and how the different elements of the content of antenatal appointments are sufficiently covered in the sources identified and if there are any other relevant accredited sources
  - if a recommendation could and should be made without reviewing new evidence, via informal committee consensus, on anything that is not covered by the sources identified but which is listed in the 2008 NICE guideline (CG62) as part of antenatal appointments, taking into consideration the criteria for this outlined above
  - if any of the elements of the content of antenatal care appointments listed in the 2008 guideline (CG62) may no longer be needed or relevant
  - if there are any additional elements not covered in the 2008 guideline (CG62) which are relevant, reflect current best practice, or are important for the implementation of the guideline and for which a recommendation could be made without reviewing new evidence, via informal consensus based on the criteria outlined above. In these instances, the committee were also informed by other suitable evidence they were aware of, including real world evidence, for example the MBRRACE-UK reports and UK Teratology Information Service.

  This was documented as a basis for later recommendation making. See Table 1 in the appendix.
- The committee then met a second time to draft recommendations based on the above. The section “Committee’s discussion of the recommendations” documents the deliberation.

Quality assessment of sources underpinning the recommendations

Quality assessment of the evidence in evidence reviews covered by this guideline or other NICE guidelines are documented in the relevant evidence reviews, available on the NICE website for the relevant guideline. According to the Developing NICE guidelines: the manual, national legislation or national policy does not need quality assessment in the same way as other evidence, given the nature of the source.

The committee’s discussion and interpretation of the evidence

Taking the woman’s history at the first antenatal appointment is standard practice and is an essential step of assessing the woman’s needs, risk factors and planning her care. The committee agreed by consensus what issues should be asked from the woman when taking history. History taking should include her medical, obstetric and family history. The committee also agreed that the other biological parent’s family history may also be relevant. The NICE guideline on antenatal and postnatal mental health includes recommendations on asking about the woman’s mental health, particularly in relation to recognising depression, anxiety and severe mental illness so cross references to relevant sections in the guideline were made. In addition to the woman’s medical and obstetric history and family history, the committee agreed that it is important to ask her about any current or recent medications,

including over-the-counter medicines, health supplements and herbal remedies. The woman's medication gives an indication of her health and it is also important to be aware of intake of any medicines or supplements that may not be safe during pregnancy so that the woman can advised on safe use of medicine during pregnancy. The committee were aware of the resources on safe medicine use in pregnancy provided by the UK Teratology Information Service and their best use of medicines in pregnancy (bumps) information leaflets that may be useful for both healthcare professionals and women.

The committee also agreed that it is important for the maternity services to be aware of the woman's allergies to plan safe care. Asking about her occupation is also important so that the healthcare providers can discuss how her work conditions might impact her pregnancy and vice versa. This is also an opportunity to make the woman aware of her statutory rights and the statutory duties that employers have in relation to the pregnant woman.

History taking is an opportunity to gain an understanding of the woman's home situation and what support she has and any issues related to her partner or family members that might impact her wellbeing, such as illness or substance use problems. This will enable the maternity services to tailor their care according to the woman's situation and needs. In some cases, this can prompt safeguarding actions.

The committee agreed that it is important to ask about behaviours such as diet, physical activity, smoking, alcohol and drug use so that the women can be advised on healthy choices. The committee agreed that the woman should also be asked about her partner's smoking. A cross reference was made to the NICE guideline on smoking: stopping in pregnancy and after childbirth which recommends that those women (and their partners or other household members) who currently smoke or recently have stopped smoking are referred to the NHS Stop Smoking Services. Supporting women to stop smoking as soon as possible is crucial to reduce the risk of adverse outcomes for the baby. The committee were aware that maternal smoking is linked to increased risk of stillbirth, premature birth, low birth weight and other complications.

The recommendation about taking history reflects current best practice. Sometimes history taking can prompt the need to review the woman's previous medical records, including when the woman has had previous antenatal and obstetric care in a different area or organisation. The committee agreed that if any medical concerns arise based on history taking or if the woman is taking long-term medication, referral to appropriate doctors should be made so that the woman's care during pregnancy is planned and optimised based on her individual situation and complications can be minimised.

The committee were aware of the disproportionate maternal mortality and stillbirth rates among women and babies from some ethnic minority backgrounds and those living in deprived areas, as highlighted by the 2020 MBRRACE-UK reports on maternal mortality and perinatal mortality. For example, black women had a more than 4-fold risk of maternal death (death during pregnancy, childbirth and up to 6 weeks after birth) and Asian women a 2-fold risk of maternal death compared to white women. Also, the stillbirth rate is significantly higher in black and Asian babies compared to white babies. Maternal mortality and stillbirth are also more prevalent in those who live in the most deprived areas (compared to those in least deprived areas). The committee discussed that healthcare professionals caring for women and babies should be aware of the increased risk of mortality in these groups. The mechanisms behind these disparities are complex and likely related to wider societal issues and inequalities. Future research should explore what interventions could improve these disparities. However, in clinical practice, it is important to recognise that the increased risk may mean that improved or additional engagement or monitoring might be beneficial.

Cardiovascular disease is the leading cause of maternal mortality in the UK according to the MBRRACE-UK report published in 2019. The committee agreed that a referral for clinical assessment by a doctor (for example a GP) should be made for pregnant women whose history suggests a potentially increased risk of undiagnosed structural cardiac condition. For

example, when the woman's family history includes cardiac abnormalities or if the woman was brought up in a country with a high incidence of rheumatic fever which could cause rheumatic heart disease. The burden of rheumatic heart disease is highest in some low income countries in sub-Saharan Africa or South Asia (Watkins 2019). As mentioned, the MBRRACE-UK report also documents the disproportionate maternal mortality among women from minority ethnic backgrounds, who may come from sub-Saharan Africa or South Asia. However the committee recognised that most maternal cardiac deaths were due to ischemic heart disease or myocardial disease and not due to undiagnosed rheumatic heart disease or other heart conditions which could be readily identified via clinical assessment. While the prevalence of such conditions is low, the potentially lifesaving impact of detecting a previously undiagnosed cardiac abnormality is hugely significant and warranted healthcare professionals considering further assessment based on a woman's history.

The committee agreed that information sharing between primary care and maternity services is important and should be discussed and agreed with the woman. Many women contact the maternity services directly without making their GP aware of the pregnancy so it is important to share information about the pregnancy with the GP. The GP might also be able to share information about the woman relevant to her care during pregnancy, including medical concerns or safeguarding issues. Furthermore, the committee agreed that it is important to keep the woman's GP aware of any complications or concerns that may occur during pregnancy so that her continued care in the community can be optimised. The committee discussed that this might not always happen in current practice but stressed the importance of good communication between healthcare providers so that information relevant to the pregnancy is not missed and the eventual transfer of care to community care is smooth.

Domestic abuse is common, always harmful and potentially detrimental for the safety of the woman and the unborn baby. Reflecting current practice, the committee agreed that women should be asked about domestic abuse at the first antenatal appointment or another time when she is alone. If the woman is accompanied by her chosen partner at appointments, the healthcare professionals should ensure that a private one-to-one moment is organised to that this can be discussed. The committee recognised that discussing the experience of domestic abuse is not easy so the discussions should be held in a kind, sensitive manner. The committee also agreed that those providing antenatal care should ensure that throughout her antenatal care the woman has opportunities and feels safe to disclose any concerns at home, including domestic abuse. Cross references to NICE guidelines on domestic violence and abuse and pregnancy and complex social factors were made for more guidance.

The committee discussed the importance of assessing the risk of female genital mutilation (FGM), both for the pregnant woman and the unborn baby so that appropriate safeguarding can take place. In the context of this guideline, this could be relevant for the pregnant woman, or the unborn baby when there is a family history or tradition of FGM. There is a legal duty to report suspected or known FGM for under-18s. At the same time, the committee recognised the sensitive nature of this topic and acknowledged the difficulty in addressing and discussing this issue with women, including when risk assessment might be relevant and how discussions should be held. Therefore, the committee agreed that the NICE guideline would benefit from signposting to a practical guidance for healthcare professionals developed by the Department of Health and Social Care on FGM safeguarding and risk assessment which includes guidance on how to do risk assessment, how to start conversations about it and what to do if there are concerns. In committee's experience this guidance is practical, helpful and widely used in clinical practice.

To reflect current best practice, the committee recommended that throughout the pregnancy at every antenatal appointment, the woman should be asked about health and wellbeing, if she (or her partner) have any concerns or questions or topics they would like to discuss. For example, there are many women who have experienced a traumatic birth and this may be an issue that the woman might want to discuss. All this will allow her plans and care to be continuously reassessed and any additional care needs identified.

The committee also agreed about the importance of documenting all findings and discussions, any changes to her situation, including medication in the woman's antenatal care records and discussing all findings with the woman at the subsequent appointment. This reflects current good practice but may sometimes be inadvertently omitted so the committee agreed to highlight this in the recommendations.

Offering to measure the woman's height and weight and calculating her body mass index (BMI) in the booking appointment is current practice and helps to plan care and assess for risk factors, for example increased risk of venous thromboembolism or pre-eclampsia associated with high BMI. It is also current practice to take a blood test to check for blood group, rhesus D status and anaemia. In relation to BMI, the committee were aware of the discussion around the appropriateness of the standard BMI cut-offs among people from Black, Asian and some other ethnic minority groups. NICE guideline on BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups addresses this issue although it excludes pregnant women.

The UK National Screening Committee recommends certain population screening programmes during pregnancy and references to these NHS screening programmes were made (HIV, syphilis, hepatitis B, sickle cell and thalassaemia, and fetal anomalies). The committee emphasised that information about the screening programmes should be provided and discussed to enable informed decision making. The women should also be made aware that she has the right to accept or decline any part of any of the screening programmes.

Part of the NHS fetal anomaly screening programme is to offer an early ultrasound scan to screen for trisomy (Down's syndrome, Edward's syndrome and Patau's syndrome). The optimal time for this screening to happen is between 11+2 and 14+1 weeks' gestation according to the NHS fetal anomaly screening programme. The committee agreed that as with current practice, it is pragmatic to coincide the early pregnancy ultrasound scan (to determine viability and gestational age and to detect multiple pregnancy) with the early screening scan. The committee agreed that the recommended weeks to offer this early pregnancy scan should be aligned with the optimal timing for the fetal trisomy screening because most women opt for the screening test. The British Medical Ultrasound Society (BMUS) offers further guidance on the method of determining gestational age.

The second ultrasound scan in the NHS fetal anomaly programme is between 18+0 to 20+6 weeks to screen for various fetal conditions, including but not restricted to heart defects, spina bifida and cleft lip. This ultrasound scan is also an opportunity to determine the location of the placenta at this stage in pregnancy. When the placenta is found to be low lying (placenta praevia) it is important to monitor this and adjust birth plans accordingly. Placenta praevia increases risk of bleeding and can prevent the baby from descending towards the cervix during labour.

A cross reference to the NICE technology appraisal guidance on routine antenatal anti-D prophylaxis for women who are rhesus D negative was made, which recommends offering anti-D prophylaxis to rhesus negative women, usually given as a single dose at 28 weeks of pregnancy. This technology appraisal should be read alongside the NICE diagnostics guideline on high-throughput non-invasive prenatal testing for fetal RHD genotype. Current practice is also to offer a blood test at this point in pregnancy including a full blood count (anaemia parameters in particular), blood group and blood antibodies.

The committee discussed the importance of providing appropriate information, support and referral when there are any unexpected findings in examinations or investigations. This guideline does not cover what the referral pathways should be like for different situations so the committee recommended referral according to local pathways.

The NICE guideline on diabetes in pregnancy offers guidance on risk assessment, testing and diagnosis of gestational diabetes. Risk assessment for gestational diabetes is relevant for all women attending antenatal care as part of their routine care so a cross reference to

the guideline was made. The guideline also recommends oral glucose tolerance test to be offered to those considered to be at risk of gestational diabetes based on the risk assessment so a reference to this was also made.

The NICE guideline on hypertension in pregnancy offer guidance on risk assessment and risk reduction of pre-eclampsia so a cross reference was made. The guideline makes recommendations about how to interpret urine test results for proteinuria but does not explicitly recommend routine testing for proteinuria although it is implied. Therefore, the committee agreed that following current practice, urine testing for proteinuria should be offered at every routine face to face appointment. Monitoring blood pressure during pregnancy was covered by another review, see evidence review K for more information. The committee agreed that routine monitoring of blood pressure and proteinuria is important so that potential hypertension or pre-eclampsia can be identified and managed early to avoid potentially serious consequences.

Other evidence reviews cover recommendations on monitoring fetal growth and wellbeing. More details are provided in evidence reviews O, P and Q.

Information provision during antenatal appointments was largely covered by evidence reviews A and B, with some further recommendations based on evidence reviews C, E and J. In addition to recommendations on what information should be provided during antenatal appointments, the committee agreed to recommend giving information about screening programmes, as recommended by the UK National Screening Committee, and immunisation such as flu, pertussis and covid during pregnancy, as recommended by the UK Joint Committee on Vaccination and Immunisation. Public Health England's Green Book gives further guidance for healthcare professionals on immunisations and references to the relevant chapters were made alongside a reference to the NICE guideline on flu vaccination. The committee were aware that NICE is currently developing a guideline on vaccine uptake in the general population. References to various other NICE guidelines were also made, including guidelines on maternal and child nutrition, vitamin D, weight management before, during and after pregnancy and postnatal care (publication planned for April 2021). In addition, the committee agreed to reference guidance on alcohol consumption during pregnancy based on the UK Chief Medical Officer's low-risk drinking guidelines.

The committee agreed that it is good practice to give general information to pregnant women about how to reduce the risk of human-to-human infections, such as parvovirus, chicken pox, cytomegalovirus, herpes simplex virus and corona virus. Such infections are not specific to pregnancy but could cause complications for the mother or the baby. Similarly information provision about group B streptococcus can be important due its potential impact on the baby. Contrary to the 2008 NICE guideline on antenatal care where a recommendation is made about informing "pregnant women younger than 25 years about the high prevalence of chlamydia infection in their age group, and give details of their local National Chlamydia Screening Programme", the committee agreed that this recommendation is no longer needed and may be unnecessarily stigmatising to young women many of whom are not at risk of having chlamydia. Rather than routinely provide information to all women under 25 years of age about this, the approach should be individualised.

Reflecting current practice, the committee agreed that in the antenatal appointments closer to birth, discussions around the woman's birth preferences and plans should be continued, including the benefits, risks and implications of different options. The committee discussed the importance of this also in relation to the 2015 Montgomery ruling which concluded that a patient should be told about all the risks associated with particular treatment options and all alternative options available to them so that they can make an informed decision. The NICE guideline on inducing labour offers guidance on the management options of prolonged pregnancy so a cross reference was made.

Cost effectiveness and resource use

Overall, the recommendations reflect and should reinforce current good practice. Clinical assessments for those who may be at an increased risk based on history are not performed in all centres. Therefore, the recommendation about considering clinical assessment to detect cardiac problems will lead to some short term increase in resource use through an increase in examinations. The number of women this recommendation applies to is relatively small and the outcomes of such assessments are potentially lifesaving and therefore it is likely that downstream cost savings and health improvements from earlier identification will outweigh the initial costs.

References

Watkins 2017

Watkins DA, Johnson CO, Colquhoun SM, Karthikeyan G, Beaton A, Bukhman G, Forouzanfar MH, Longenecker CT, Mayosi BM, Mensah GA, Nascimento BR, Ribeiro ALP, Sable CA, Steer AC, Naghavi M, Mokdad AH, Murray CJL, Vos T, Carapetis JR, Roth GA. Global, Regional, and National Burden of Rheumatic Heart Disease, 1990-2015, N Engl J Med, 377, 8, 713-7

Appendices

Appendix A - Mapping of sources to answer the review question

Mapping of sources to answer the review question: What should the content of antenatal appointments be?

Table 1

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
Booking appointment		
Give the following information (supported by written information and antenatal classes), with an opportunity to discuss issues and ask questions. Refer to section 1.1.1 for more about giving antenatal information. Topics covered should include: • how the baby develops during pregnancy • nutrition and diet, including vitamin D supplementation • exercise, including pelvic floor exercises • antenatal screening, including risks and benefits of the screening tests • pregnancy care pathway • place of birth (refer to NICE's guideline on intrapartum care) • breastfeeding, including workshops • participant led antenatal classes • maternity benefits.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups? Nutrition and diet – NICE guidelines on maternal and child nutrition (PH11) and on vitamin D (PH56) Exercise – covered by NICE guideline on weight management before, during and after pregnancy (PH27) although mainly from the point of view of weight management. Detailed recommendations about what type of exercise, how much exercise and so on would require an evidence review,	Recommendation about information on alcohol and smoking needed. A cross-reference to NICE guideline on smoking: stopping in pregnancy and after childbirth (PH26) should be made. Potentially a reference to the UK Chief Medical Officers' low-risk drinking guidelines for advice on drinking in pregnancy. Recommendation about information about vaccinations (flu and pertussis) needed – cross-reference to NICE guideline on flu vaccination (NG103) and reference to Public Health England guidance on immunisation for influenza (Green Book, chapter 19) and for pertussis (whooping cough, Green Book, chapter 24). NICE guideline on vaccine uptake in the general population is currently in development. Advice on risk reduction of common human-to-human infections which are not screened for, for example parvovirus, chicken pox or corona virus, is not in the scope and could be a question of its

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
	therefore, only a general comment can be made via cross-referencing to PH27. Place of birth – NICE guideline on intrapartum care for healthy women and babies (CG190), recommendations 1.1.1-1.1.9 Breastfeeding – NICE guideline on postnatal care (currently being updated)	own, therefore, not much can be said but some potential for a generic comment via informal consensus could be made about giving general advice avoiding contact with those known to have infections and to inform midwife/GP if they have had contact or develop symptoms.
Identify women who may need additional care (see appendix C) and plan pattern of care for the pregnancy	NICE guideline on intrapartum care for healthy women and babies (CG190), recommendation 1.10 NICE guideline intrapartum care for women with existing medical conditions or obstetric complications and their babies (NG121)	Taking history and reviewing of medical and obstetric history current medications (including health supplements) can be agreed via informal consensus because it is common sense and good practice. Important to identify anything that could warrant a different pathway for the woman or a referral. A recommendation about identification of underlying cardiac problems through a clinical assessment by a doctor in women who have not been assessed before or who have personal or family risk factors would be important because based on the 2019 report MBRRACE-UK: Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–17, cardiac problems were the most common cause of maternal mortality in the UK. A 'weak' recommendation could be made via informal consensus based on the evidence in the MBRRACE-UK report. The potential resource impact would be offset by potentially avoiding devastating outcomes.

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
Check blood group and rhesus D status	-	A recommendation can be agreed via informal consensus because there is no clinical uncertainty, has to be done, and it is current best practice, no resource impact.
Offer screening for haemoglobinopathies, anaemia, red cell alloantibodies, hepatitis B virus, HIV and syphilis	Haemoglobinopathies - NHS sickle cell and thalassaemia (SCT) screening programme Anaemia – currently under review by UK National Screening Committee Red cell alloantibodies - UK National Screening Committee – national population screening not recommended Hepatitis B, HIV, syphilis – NHS infectious diseases in pregnancy screening (IDPS) programme	Recommendation about taking a full blood count should be made via informal consensus, reflects current best practice, no resource impact.
Offer screening for asymptomatic bacteriuria	UK National Screening Committee (national population screening not recommended)	
Inform pregnant women younger than 25 years about the high prevalence of chlamydia infection in their age group, and give details of their local National Chlamydia Screening Programme	UK National Screening Committee (national population screening not recommended) National Chlamydia Screening Programme	This recommendation is probably not needed, unnecessary stigmatisation of young women of which many are not in the high risk group. Approach should be individualised.
Offering screening for Down's syndrome	NHS Fetal Anomaly Screening programme (FASP)	
Offer early ultrasound scan for gestational age assessment	Originally review question was planned on “when should ultrasound estimation of gestational age be carried out in pregnancy?”, however, a decision was made not to conduct a new evidence review on this. Instead the committee is to discuss if current (CG62) recommendations can be adopted and carried over.	
Offer ultrasound screening for structural anomalies	NHS Fetal Anomaly Screening programme (FASP)	

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
Measure height, weight and calculate body mass index	-	This recommendation can be agreed via informal consensus because there is no clinical uncertainty, has to be done, reflects current practice, no resource impact.
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Offer screening for gestational diabetes and pre-eclampsia using risk factors	NICE guideline on diabetes in pregnancy (NG3), recommendation 1.2.2 NICE guideline on hypertension in pregnancy (NG133), recommendations 1.1.2-1.1.3	Risk assessment for venous thromboembolism in pregnancy covered by this guideline's evidence review N: What are the risk factors for venous thromboembolism (VTE) in pregnant women?
Identify women who have had genital mutilation	-	A recommendation about female genital mutilation (FGM) can be agreed via informal consensus. FGM or risk of FGM for unborn baby girl needs to be identified. There is a legal duty to report suspected FGM on a person under the age of 18 years. For this guideline this could mean either the mother or the unborn baby girl when there is family history or tradition of FGM. Department of Health and Social Care collects this data nationally via Female Genital Mutilation Enhanced Dataset. Department of Health and Social Care has also produced practical guidance for healthcare professionals on safeguarding and risk assessment for FGM. NICE guideline on pregnancy and complex social factors (CG110) includes FGM in their definition of domestic abuse and will be cross-referred to,

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
		however, this guideline does not cover identification of FGM (or domestic abuse). In addition, a recommendation about asking about domestic abuse can be agreed via informal consensus. This is standard practice and part of safeguarding of the woman and the unborn baby. Reference to the NICE guideline on domestic violence and abuse and the section on pregnant women who experience domestic abuse in the NICE guideline on pregnancy and complex social factors can be made.
Ask about any past or present severe mental illness or psychiatric treatment	NICE guideline on antenatal and postnatal mental health (CG192)	
Ask about mood to identify possible depression	NICE guideline on antenatal and postnatal mental health (CG192)	
Ask about the woman's occupation to identify potential risks.	-	This recommendation can be agreed via informal consensus. This is standard practice and required to understand the circumstances of the family and to provide general advice to women. Also related to making women aware of their rights, including that their employer is responsible for assessing the risks to the employee and the baby. No clinical uncertainty or resource impact.
Appointment at 16 weeks		
Review, discuss and record the results of all screening tests undertaken; reassess planned pattern of care for the pregnancy and identify women who need additional care	-	This recommendation can be agreed via informal consensus because this is a logical follow-up after tests have been done. Common sense and current practice, no clinical uncertainty or resource impact.
Investigate a haemoglobin level below 11 g/100 ml and consider iron supplementation if indicated	UK National Screening Committee currently reviewing screening for anaemia	Depends on UK National Screening Committee review but checking for full blood count reflects current good practice.

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Give information, with an opportunity to discuss issues and ask questions, including discussion of the routine anomaly scan; offer verbal information supported by antenatal classes and written information.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups?	
Appointment at 18 to 20 weeks		
At 18 to 20 weeks, if the woman chooses, an ultrasound scan should be performed for the detection of structural anomalies. For a woman whose placenta is found to extend across the internal cervical os at this time, another scan at 32 weeks should be offered.	NHS Fetal Anomaly Screening programme (FASP)	
Appointment at 25 weeks (nulliparous women)		
Measure and plot symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
		resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Give information, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups?	
Appointment at 28 weeks		
Offer a second screening for anaemia and atypical red cell alloantibodies	Currently being reviewed by UK National Screening Committee	
Investigate a haemoglobin level below 10.5 g/100 ml and consider iron supplementation, if indicated	UK National Screening Committee currently reviewing screening for anaemia	Depends on UK National Screening Committee review.
Offer anti D prophylaxis to rhesus negative women	NICE technology appraisal on routine antenatal anti-D prophylaxis for women who are rhesus D negative (TA156)	
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Measure and plot symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
Give information, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups?	In addition, recommendation about asking about fetal movements covered by this guideline's evidence review P: Is fetal movement monitoring from 28 weeks effective?
Appointment at 31 weeks (nulliparous women)		
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Measure and plot symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	
Give information, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)?	In addition, recommendation about asking about fetal movements covered by this guideline's evidence review P: Is fetal movement monitoring from 28 weeks effective?

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
	Evidence review E: How effective is the support provided by antenatal classes and groups?	
Review, discuss and record the results of screening tests undertaken at 28 weeks; reassess planned pattern of care for the pregnancy and identify women who need additional care.		This recommendation can be agreed via informal consensus because this is a logical follow-up after tests have been done. Common sense and current practice, no clinical uncertainty or resource impact.
Appointment at 34 weeks		
Give information (supported by written information and antenatal classes), with an opportunity to discuss issues and ask questions. Refer to section 1.1.1 for more about giving antenatal information. Topics covered should include: • preparation for labour and birth, including information about coping with pain in labour and the birth plan • recognition of active labour.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups?	In addition, recommendation about asking about fetal movements covered by this guideline's evidence review P: Is fetal movement monitoring from 28 weeks effective?
Offer a second dose of anti D to rhesus negative women	NICE technology appraisal on routine antenatal anti-D prophylaxis for women who are rhesus D negative (TA156)	
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Measure and plot symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
Give information, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups?	
Review, discuss and record the results of screening tests undertaken at 28 weeks; reassess planned pattern of care for the pregnancy and identify women who need additional care.		This recommendation can be agreed via informal consensus because this is a logical follow-up after tests have been done. Common sense and current practice, no clinical uncertainty or resource impact.
Appointment at 36 weeks		
Give the following information (supported by written information and antenatal classes), with an opportunity to discuss issues and ask questions. Refer to section 1.1.1 for more about giving antenatal information. Topics covered should include: • breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF Baby Friendly Initiative • care of the new baby • vitamin K prophylaxis and newborn screening tests • postnatal self care	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups? NICE guideline on postnatal care (currently being updated)	In addition, recommendation about asking about fetal movements covered by this guideline's evidence review P: Is fetal movement monitoring from 28 weeks effective?

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
• awareness of 'baby blues' and postnatal depression.		
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Measure and plot symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	
Check position of baby	Evidence review L: What is the effectiveness of routine scanning between 36+0 and 38+6 weeks of pregnancy compared to standard care regarding breech presentation?	
For women whose babies are in the breech presentation, offer external cephalic version (ECV)	Evidence review M: What is the most effective way of managing a longitudinal lie fetal malpresentation (i.e. breech presentation) in late pregnancy?	
Appointment at 38 weeks		
Measurement of blood pressure and urine testing for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Measurement and plotting of symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	
Information giving, including options for management of prolonged pregnancy, with an opportunity to discuss issues and ask questions;	NICE guideline on inducing labour (CG70)	In addition, recommendation about asking about fetal movements covered by this guideline's

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
verbal information supported by antenatal classes and written information.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)? Evidence review E: How effective is the support provided by antenatal classes and groups?	evidence review P: Is fetal movement monitoring from 28 weeks effective?
Appointment at 40 weeks (nulliparous women)		
Measure blood pressure and test urine for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Measure and plot symphysis–fundal height	Evidence review O: What is best method using third trimester measurements to predict birth weight?	
Give information, including further discussion about the options for prolonged pregnancy, with an opportunity to discuss issues and ask questions; offer verbal information supported by antenatal classes and written information.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)?	In addition, recommendation about asking about fetal movements covered by this guideline's evidence review P: Is fetal movement monitoring from 28 weeks effective?

Content outlined in 2008 NICE guideline on antenatal care for uncomplicated pregnancies (CG62), Appendix D: Antenatal appointments (schedule and content)	Relevant sources covering the topics	Further comments by the committee on gaps identified or where recommendation on a topic may no longer be needed
	Evidence review E: How effective is the support provided by antenatal classes and groups?	
Appointment at 41 weeks (for women who have not given birth by 41 weeks)		
A membrane sweep should be offered	NICE guideline on inducing labour (CG70)	
Induction of labour should be offered	NICE guideline on inducing labour (CG70)	
Blood pressure should be measured and urine tested for proteinuria	Blood pressure – evidence review K: What is the most effective way of identifying hypertension in pregnancy?	A recommendation on urine test for proteinuria can be agreed via informal consensus because there is no clinical uncertainty, reflects current practice, no resource impact. NICE guideline on hypertension in pregnancy (NG133) covers pre-eclampsia but not screening for proteinuria.
Symphysis–fundal height should be measured and plotted	Evidence review O: What is best method using third trimester measurements to predict birth weight?	
Information should be given, with an opportunity to discuss issues and ask questions; verbal information supported by written information.	Evidence review A: What information is valued by women, their partners and families, and what information should be given to them, as part of their antenatal care? Evidence review B: What approach to information giving during antenatal care is effective (including timing and mode of provision)?	In addition, recommendation about asking about fetal movements covered by this guideline's evidence review P: Is fetal movement monitoring from 28 weeks effective?