NICE National Institute for Health and Care Excellence

Royal College of Obstetricians & Gynaecologists

NICE guideline

Antenatal care

NICE guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services 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 complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces CG62 and ES20.

This guideline is the basis of QS22, QS35, QS105, QS204 and QS178.

This guideline should be read in conjunction with NG137, NG207, NG192 and NG235.

Overview

This guideline covers the routine antenatal care that women and their babies should receive. It aims to ensure that pregnant women are offered regular check-ups, information and support. We have also published a guideline on postnatal care, which covers the topics of emotional attachment and baby feeding.

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby.

Who is it for?

- Healthcare professionals
- Commissioners of antenatal care services
- Women using antenatal services, their partners, their families, and the public

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Supporting women to make decisions about their care is important during pregnancy. Healthcare professionals should ensure that women have the information they need to make decisions and to give consent in line with General Medical Council (GMC) guidance, the Nursing and Midwifery Council (NMC) Code and the 2015 Montgomery ruling.

1.1 Organisation and delivery of antenatal care

Starting antenatal care

1.1.1 Ensure that antenatal care can be started in a variety of straightforward ways, depending on women's needs and circumstances, for example, by self-referral, referral by a GP, midwife or another healthcare professional, or through a school nurse, community centre or refugee hostel.

1.1.2 At the point of antenatal care referral:

- Provide an easy-to-complete referral form.
- Offer early pregnancy health and wellbeing information before the booking appointment. This should include information about modifiable factors that may affect the pregnancy, including stopping smoking, avoiding alcohol, taking supplements, and eating healthily. See also recommendation 1.3.9 and

the NICE guidelines on maternal and child nutrition, vitamin D, and tobacco: preventing uptake, promoting quitting and treating dependence.

- Ensure that the materials are available in different languages or formats such as digital, printed, braille or Easy Read.

1.1.3 The referral form for women to start antenatal care should:

- enable healthcare professionals to identify women with:
  - specific health and social care needs
  - risk factors, including those that can potentially be addressed before the booking appointment, for example, smoking
- include contact details about the woman's GP.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on starting antenatal care.

Full details of the evidence and the committee's discussion are in evidence review F: accessing antenatal care.

Antenatal appointments

1.1.4 Offer a first antenatal (booking) appointment with a midwife to take place by 10+0 weeks of pregnancy.

1.1.5 If women contact or are referred to maternity services later than 9+0 weeks of pregnancy, offer a first antenatal (booking) appointment to take place within 2 weeks if possible.

1.1.6 If a woman books late in pregnancy, ask about the reasons for the late booking because it may reveal social, psychological or medical issues that need to be addressed.

1.1.7 Plan 10 routine antenatal appointments with a midwife or doctor for nulliparous women. (See schedule of appointments.)

1.1.8 Plan 7 routine antenatal appointments with a midwife or doctor for parous women. (See schedule of appointments.)

1.1.9 Also see the NICE guideline on pregnancy and complex social factors for:

- women who misuse substances
- recent migrants, asylum seekers or refugees, or women who have difficulty reading or speaking English
- young women aged under 20
- women who experience domestic abuse.

1.1.10 Offer additional or longer antenatal appointments if needed, depending on the woman's medical, social and emotional needs. Also see the NICE guidelines on pregnancy and complex social factors, intrapartum care for women with existing medical conditions or obstetric complications and their babies, hypertension in pregnancy, diabetes in pregnancy and twin and triplet pregnancy.

1.1.11 Ensure that reliable interpreting services are available when needed, including British Sign Language. Interpreters should be independent of the woman rather than using a family member or friend.

1.1.12 Those responsible for planning and delivering antenatal services should aim to provide continuity of carer.

1.1.13 Ensure that there is effective and prompt communication between healthcare professionals who are involved in the woman's care during pregnancy.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on antenatal appointments.

Full details of the evidence and the committee's discussion are in:

- evidence review H: timing of first antenatal appointment
- evidence review I: number of antenatal appointments
- evidence review J: referral and delivery of antenatal care.

Involving partners

1.1.14 A woman can be supported by a partner during her pregnancy so healthcare professionals should:

- involve partners according to the woman's wishes **and**
- inform the woman that she is welcome to bring a partner to antenatal appointments and classes.

1.1.15 Consider arranging the timing of antenatal classes so that the pregnant woman's partner can attend, if the woman wishes.

1.1.16 When planning and delivering antenatal services, ensure that the environment is welcoming for partners as well as pregnant women by, for example:

- providing information about how partners can be involved in supporting the woman during and after pregnancy
- providing information about pregnancy for partners as well as pregnant women
- displaying positive images of partner involvement (for example, on notice boards and in waiting areas)
- providing seating in consultation rooms for both the woman and her partner

- considering providing opportunities for partners to attend appointments remotely as appropriate.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on involving partners.

Full details of the evidence and the committee's discussion are in evidence review C: involving partners and evidence review B: approaches to information provision.

1.2 Routine antenatal clinical care

Taking and recording the woman's history

1.2.1 At the first antenatal (booking) appointment, ask the woman about:

- her medical history, obstetric history and family history (of both biological parents)
- previous or current mental health concerns such as depression, anxiety, severe mental illness, psychological trauma or psychiatric treatment, to identify possible mental health problems in line with the section on recognising mental health problems in pregnancy and the postnatal period and referral in the NICE guideline on antenatal and postnatal mental health
- current and recent medicines, including over-the-counter medicines, health supplements and herbal remedies
- allergies
- her occupation, discussing any risks and concerns
- her family and home situation, available support network and any health or other issues affecting her partner or family members that may be significant for her health and wellbeing
- other people who may be involved in the care of the baby

- contact details for her partner and her next of kin
- factors such as nutrition and diet, physical activity, smoking and tobacco use, alcohol consumption and recreational drug use (see also recommendations 1.3.8 and 1.3.9).

1.2.2 Consider reviewing the woman's previous medical records if needed, including records held by other healthcare providers.

1.2.3 Be aware that, according to the 2020 MBRRACE-UK reports on maternal and perinatal mortality, 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. The reports showed that:

- compared with white women (8/100,000), the risk of maternal death during pregnancy and up to 6 weeks after birth is:
  - 4 times higher in black women (34/100,000)
  - 3 times higher in women with mixed ethnic background (25/100,000)
  - 2 times higher in Asian women (15/100,000; does not include Chinese women)
- compared with white babies (34/10,000), the stillbirth rate is
  - more than twice as high in black babies (74/10,000)
  - around 50% higher in Asian babies (53/10,000)
- women living in the most deprived areas (15/100,000) are more than 2.5 times more likely to die compared with women living in the least deprived areas (6/100,000)
- the stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for women living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000).

1.2.4 If the woman or her partner smokes or has stopped smoking within the past

2 weeks, offer a referral to NHS Stop Smoking Services in line with the NICE guideline on tobacco: preventing uptake, promoting quitting and treating dependence.

1.2.5 Ask the woman about domestic abuse in a kind, sensitive manner at the first antenatal (booking) appointment, or at the earliest opportunity when she is alone. Ensure that there is an opportunity to have a private, one-to-one discussion. Also see 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.

1.2.6 Assess the woman's risk of and, if appropriate, discuss female genital mutilation (FGM) in a kind, sensitive manner. Take appropriate action in line with UK government guidance on safeguarding women and girls at risk of FGM.

1.2.7 Refer the woman for a clinical assessment by a doctor to detect cardiac conditions if there is a concern based on the pregnant woman's personal or family history. See also the section on heart disease in the NICE guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies.

1.2.8 Refer the woman to an obstetrician or other relevant doctor if there are any medical concerns or if review of current long-term medicines is needed.

1.2.9 After discussion with and agreement from the woman, contact the woman's GP to share information about the pregnancy and potential concerns or complications during pregnancy.

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

- ask the woman about her general health and wellbeing
- ask the woman (and her partner, if present) if there are any concerns they would like to discuss
- provide a safe environment and opportunities for the woman to discuss topics such as concerns at home, domestic abuse, concerns about the birth (for example, if she previously had a traumatic birth) or mental health

concerns

- review and reassess the plan of care for the pregnancy
- identify women who need additional care.

  For guidance on organising, planning and providing care and support for pregnant women who are approaching end of life and their carers, see the NICE guideline on end of life care for adults: service delivery.

1.2.11 At every antenatal contact, update the woman's antenatal records to include details of history, test results, examination findings, medicines and discussions.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on taking and recording the woman's history.

Full details of the evidence and the committee's discussion are in evidence review G: content of antenatal appointments.

Examinations and investigations

1.2.12 At the first face-to-face antenatal appointment:

- offer to measure the woman's height and weight and calculate body mass index
- offer a blood test to check full blood count, blood group and rhesus D status.

1.2.13 At the first antenatal (booking) appointment, discuss and share information about, and then offer, the following screening programmes:

- NHS infectious diseases in pregnancy screening programme (HIV, syphilis and hepatitis B)
- NHS sickle cell and thalassaemia screening programme
- NHS fetal anomaly screening programme.

Inform the woman that she can accept or decline any part of any of the screening programmes offered.

1.2.14 Offer pregnant women an ultrasound scan to take place between 11+2 weeks and 14+1 weeks to:

- determine gestational age
- detect multiple pregnancy
- and if opted for, screen for Down's syndrome, Edwards' syndrome and Patau's syndrome (see the NHS fetal anomaly screening programme).

1.2.15 Offer pregnant women an ultrasound scan to take place between 18+0 weeks and 20+6 weeks to:

- screen for fetal anomalies (see the NHS fetal anomaly screening programme)
- determine placental location.

1.2.16 At the antenatal appointment at 28 weeks, offer:

- a blood test to check full blood count, blood group and antibodies
- anti-D prophylaxis to rhesus D-negative women who are not known to be sensitised to the rhesus D antigen in line with NICE's technology appraisal guidance on routine antenatal anti-D prophylaxis (TA156, 2008), also see NICE's diagnostics guidance on high-throughput non-invasive prenatal testing for fetal RHD genotype.

1.2.17 If there are any unexpected results from examinations or investigations, offer referral according to local pathways and ensure appropriate information provision and support.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on examinations and investigations.

Full details of the evidence and the committee's discussion are in evidence review G: content of antenatal appointments.

Venous thromboembolism

1.2.18 Assess the woman's risk factors for venous thromboembolism at the first antenatal (booking) appointment, and after any hospital admission or significant health event during pregnancy. Consider using guidance by an appropriate professional body, for example, the Royal College of Obstetricians and Gynaecologists' guideline on reducing the risk of venous thromboembolism during pregnancy.

1.2.19 For pregnant women who are admitted to a hospital or a midwife-led unit, see the section on interventions for pregnant women and women who gave birth or had a miscarriage or termination of pregnancy in the past 6 weeks in the NICE guideline on venous thromboembolism in over 16s.

1.2.20 For women at risk of venous thromboembolism, offer referral to an obstetrician for further management.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on venous thromboembolism.

Full details of the evidence and the committee's discussion are in evidence review N: risk factors for venous thromboembolism in pregnancy.

Gestational diabetes

1.2.21 At the first antenatal (booking) appointment, assess the woman's risk factors for

gestational diabetes in line with the recommendations on gestational diabetes risk assessment in the NICE guideline on diabetes in pregnancy.

1.2.22 If a woman is at risk of gestational diabetes, offer referral for an oral glucose tolerance test to take place between 24+0 weeks and 28+0 weeks in line with the recommendations on gestational diabetes risk assessment and the recommendations on gestational diabetes testing in the NICE guideline on diabetes in pregnancy.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on gestational diabetes.

Full details of the evidence and the committee's discussion are in evidence review G: content of antenatal appointments.

Pre-eclampsia and hypertension in pregnancy

1.2.23 At the first antenatal (booking) appointment and again in the second trimester, assess the woman's risk factors for pre-eclampsia, and advise those at risk to take aspirin in line with the section on antiplatelet agents in the NICE guideline on hypertension in pregnancy.

1.2.24 Measure and record the woman's blood pressure at every routine face-to-face antenatal appointment using a device validated for use in pregnancy, and following the recommendations on measuring blood pressure in the NICE guideline on hypertension in adults.

1.2.25 For women under 20+0 weeks with hypertension, follow the recommendations on the management of chronic hypertension in pregnancy in the NICE guideline on hypertension in pregnancy.

1.2.26 Refer women over 20+0 weeks with a first episode of hypertension (blood pressure of 140/90 mmHg or higher) to secondary care to be seen within 24 hours. See the recommendations on diagnosing hypertension in the NICE guideline on hypertension in adults.

1.2.27 Urgently refer women with severe hypertension (blood pressure of 160/110 mmHg or higher) to secondary care to be seen on the same day. The urgency of the referral should be determined by an overall clinical assessment.

1.2.28 Offer a urine dipstick test for proteinuria at every routine face-to-face antenatal appointment.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on pre-eclampsia and hypertension in pregnancy.

Full details of the evidence and the committee's discussion are in evidence review K: identification of hypertension in pregnancy and evidence review G: content of antenatal appointments.

Monitoring fetal growth and wellbeing

1.2.29 Offer a risk assessment for fetal growth restriction at the first antenatal (booking) appointment, and again in the second trimester. Consider using guidance by an appropriate professional or national body, for example, the Royal College of Obstetricians and Gynaecologists' guideline on the investigation and management of the small-for-gestational-age fetus or the NHS saving babies' lives care bundle version 2.

1.2.30 Offer symphysis fundal height measurement at each antenatal appointment after 24+0 weeks (but no more frequently than every 2 weeks) for women with a singleton pregnancy unless the woman is having regular growth scans. Plot the measurement onto a growth chart in line with the NHS saving babies' lives care bundle version 2.

1.2.31 If there are concerns that the symphysis fundal height is large for gestational age, consider an ultrasound scan for fetal growth and wellbeing.

1.2.32 If there are concerns that the symphysis fundal height is small for gestational age, offer an ultrasound scan for fetal growth and wellbeing, the urgency of which may depend on additional clinical findings, for example, reduced fetal

movements or raised maternal blood pressure.

1.2.33 Do not routinely offer ultrasound scans after 28 weeks for uncomplicated singleton pregnancies.

1.2.34 Discuss the topic of babies' movements with the woman after 24+0 weeks, and:

- ask if she has any concerns about her baby's movements at each antenatal contact after 24+0 weeks
- advise her to contact maternity services at any time of day or night if she has any concerns about her baby's movements or she notices reduced fetal movements after 24+0 weeks
- assess the woman and baby if there are any concerns about the baby's movements.

1.2.35 Service providers should recognise that the use of structured fetal movement awareness packages, such as the one studied in the AFFIRM trial, has not been shown to reduce stillbirth rates.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on monitoring fetal growth and wellbeing.

Full details of the evidence and the committee's discussion are in:

- evidence review O: monitoring fetal growth
- evidence review P: fetal movement monitoring
- evidence review Q: routine third trimester ultrasound for fetal growth.

Breech presentation

1.2.36 Offer abdominal palpation at all appointments after 36+0 weeks to identify possible breech presentation for women with a singleton pregnancy.

1.2.37 If breech presentation is suspected on abdominal palpation, offer an ultrasound scan to determine the presentation.

1.2.38 For women with an uncomplicated singleton pregnancy with breech presentation confirmed after 36+0 weeks:

- discuss the different options available and their benefits, risks and implications, including:
  - external cephalic version (to turn the baby from bottom to head down)
  - breech vaginal birth
  - elective caesarean birth
- for women who prefer cephalic (head-down) vaginal birth, offer external cephalic version.

  Also see the recommendations on breech presentation in the NICE guideline on caesarean birth, and the recommendations on breech presenting in labour in the NICE guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on breech presentation.

Full details of the evidence and the committee's discussion are in evidence review L: identification of breech presentation and evidence review M: management of breech presentation.

1.3 Information and support for pregnant women and their partners

Communication – key principles

1.3.1 When caring for a pregnant woman, listen to her and be responsive to her needs and preferences. Also see the NICE guideline on patient experience in adult NHS services, in particular the sections on communication and information, and the NICE guideline on shared decision making.

1.3.2 Ensure that when offering any assessment, intervention or procedure, the risks, benefits and implications are discussed with the woman and she is aware that she has a right to decline.

1.3.3 Women's decisions should be respected, even when this is contrary to the views of the healthcare professional.

1.3.4 When giving women (and their partners) information about antenatal care, use clear language, and tailor the timing, content and delivery of information to the needs and preferences of the woman and her stage of pregnancy. Information should support shared decision making between the woman and her healthcare team, and be:

- offered on a one-to-one or couple basis
- supplemented by group discussions (women only or women and partners)
- supplemented by written information in a suitable format, for example, digital, printed, braille or Easy Read
- offered throughout the woman's care
- individualised and sensitive
- supportive and respectful
- evidence-based and consistent
- translated into other languages if needed.

For more guidance on communication, providing information (including different formats and languages), and shared decision making, see the NICE guideline on patient experience in adult NHS services and the NHS Accessible Information Standard.

1.3.5 Explore the knowledge and understanding that the woman (and her partner) has about each topic to individualise the discussion.

1.3.6 Check that the woman (and her partner) understands the information that has been given, and how it relates to them. Provide regular opportunities to ask questions, and set aside enough time to discuss any concerns.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on communication – key principles.

Full details of the evidence and the committee's discussion are in:

- evidence review B: approaches to information provision
- evidence review A: information provision
- evidence review J: referral and delivery of antenatal care.

Information about antenatal care

1.3.7 At the first antenatal (booking) appointment, discuss antenatal care with the woman (and her partner) and provide her schedule of antenatal appointments.

1.3.8 At the first antenatal (booking) appointment (and later if appropriate), discuss and give information on:

- what antenatal care involves and why it is important
- the planned number of antenatal appointments

- where antenatal appointments will take place
- which healthcare professionals will be involved in antenatal appointments
- how to contact the midwifery team for non-urgent advice
- how to contact the maternity service about urgent concerns, such as pain and bleeding
- screening programmes: what blood tests and ultrasound scans are offered and why
- how the baby develops during pregnancy
- what to expect at each stage of the pregnancy
- physical and emotional changes during the pregnancy
- mental health during the pregnancy
- relationship changes during the pregnancy
- how the woman and her partner can support each other
- immunisation for flu, pertussis (whooping cough), respiratory syncytial virus (RSV) and other infections during pregnancy, in line with the NICE guideline on flu vaccination and the UK Health Security Agency's green book on immunisation against infectious disease
- infections that can impact on the baby in pregnancy or during birth (such as group B streptococcus, herpes simplex and cytomegalovirus)
- reducing the risk of infections, for example, encouraging hand washing
- safe use of medicines, health supplements and herbal remedies during pregnancy
- resources and support for expectant and new parents
- how to get in touch with local or national peer support services.

1.3.9 At the first antenatal (booking) appointment, and later if appropriate, discuss and

give information about nutrition and diet, physical activity, smoking cessation and recreational drug use in a non-judgemental, compassionate and personalised way. See the NICE guidelines on maternal and child nutrition, vitamin D, tobacco: preventing uptake, promoting quitting and treating dependence, and the section on pregnant women who misuse substances (alcohol and/or drugs) in the NICE guideline on pregnancy and complex social factors.

1.3.10 At the first antenatal (booking) appointment, and later if appropriate, discuss alcohol consumption and follow the UK Chief Medical Officers' low-risk drinking guidelines. Explain that:

- there is no known safe level of alcohol consumption during pregnancy
- drinking alcohol during the pregnancy can lead to long-term harm to the baby
- the safest approach is to avoid alcohol altogether to minimise risks to the baby.

1.3.11 Throughout the pregnancy, discuss and give information on:

- physical and emotional changes during the pregnancy
- relationship changes during the pregnancy
- how the woman and her partner can support each other
- resources and support for expectant and new parents
- how the parents can bond with their baby and the importance of emotional attachment (also see the section on promoting emotional attachment in the NICE guideline on postnatal care)
- the results of any blood or screening tests from previous appointments.

1.3.12 See the NICE guideline on pelvic floor dysfunction for guidance on:

- providing information about pelvic floor dysfunction (recommendation 1.1.6)
- pelvic floor muscle training during and after pregnancy.

1.3.13 After 24 weeks, discuss babies' movements (see also recommendation 1.2.34).

1.3.14 Before 28 weeks, start talking with the woman about her birth preferences and the implications, benefits and risks of different options (see the section on planning place of birth in the NICE guideline on intrapartum care and the section on planning mode of birth in the NICE guideline on caesarean birth).

1.3.15 After 28 weeks, discuss and give information on:

- preparing for labour and birth, including information about coping in labour and creating a birth plan
- recognising active labour
- the postnatal period, including:
  - care of the new baby
  - the baby's feeding
  - vitamin K prophylaxis
  - newborn screening
  - postnatal self-care, including pelvic floor exercises
  - awareness of mood changes and postnatal mental health.

    Also see the NICE guideline on postnatal care.

1.3.16 From 28 weeks onwards, as appropriate, continue the discussions and confirm the woman's birth preferences, discussing the implications, benefits and risks of all the options.

1.3.17 From 38 weeks, discuss prolonged pregnancy and options on how to manage this, in line with the NICE guideline on inducing labour.

1.3.18 See the NICE guideline on preterm labour and birth for women at increased risk of, or with symptoms and signs of, preterm labour (before 37 weeks), and women having a planned preterm birth.

1.3.19 Provide appropriate information and support for women whose baby is

considered to be at an increased risk of neonatal admission.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on information about antenatal care.

Full details of the evidence and the committee's discussion are in:

- evidence review A: information provision
- evidence review B: approaches to information provision
- evidence review C: involving partners
- evidence review D: peer support
- evidence review G: content of antenatal appointments
- evidence review J: referral and delivery of antenatal care
- evidence review P: fetal movement monitoring.

Antenatal classes

1.3.20 Offer nulliparous women (and their partners) antenatal classes that include topics such as:

- preparing for labour and birth
- supporting each other throughout the pregnancy and after birth
- common events in labour and birth
- how to care for the baby
- how the parents can bond with their baby and the importance of emotional attachment (also see the section on promoting emotional attachment in the NICE guideline on postnatal care)

- planning and managing their baby's feeding (also see the section on planning and supporting babies' feeding in the NICE guideline on postnatal care).

1.3.21 Consider antenatal classes for multiparous women (and their partners) if they could benefit from attending (for example, if they have had a long gap between pregnancies, or have never attended antenatal classes before).

1.3.22 Ensure that antenatal classes are welcoming, accessible and adapted to meet the needs of local communities. Also see the section on young pregnant women aged under 20 in the NICE guideline on pregnancy and complex social factors.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on antenatal classes.

Full details of the evidence and the committee's discussion are in evidence review E: antenatal classes and evidence review B: approaches to information provision.

Peer support

1.3.23 Discuss the potential benefits of peer support with pregnant women (and their partners), and explain how it may:

- provide practical support
- help to build confidence
- reduce feelings of isolation.

1.3.24 Offer pregnant women (and their partners) information about how to access local and national peer support services.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on peer support.

Full details of the evidence and the committee's discussion are in evidence review D: peer support.

Sleep position

1.3.25 Advise women to avoid going to sleep on their back after 28 weeks of pregnancy and to consider using pillows, for example, to maintain their position while sleeping.

1.3.26 Explain to the woman that there may be a link between going to sleep on her back and stillbirth in late pregnancy (after 28 weeks).

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on sleep position.

Full details of the evidence and the committee's discussion are in evidence review W: maternal sleep position during pregnancy.

1.4 Interventions for common problems during pregnancy

Nausea and vomiting

1.4.1 Reassure women that mild to moderate nausea and vomiting are common in pregnancy, and are likely to resolve before 16 to 20 weeks.

1.4.2 Recognise that by the time women seek advice from healthcare professionals about nausea and vomiting in pregnancy, they may have already tried a number of different interventions.

1.4.3 For pregnant women with mild-to-moderate nausea and vomiting who prefer a non-pharmacological option, suggest that they try ginger.

1.4.4 When considering pharmacological treatments for nausea and vomiting in pregnancy, discuss the advantages and disadvantages of different antiemetics with the woman. Take into account her preferences and her experience with treatments in previous pregnancies. See table 1 on the advantages and disadvantages of different pharmacological treatments for nausea and vomiting

in pregnancy to support shared decision making.

1.4.5 For pregnant women with nausea and vomiting who choose a pharmacological treatment, offer an antiemetic (see table 1 on the advantages and disadvantages of different pharmacological treatments for nausea and vomiting in pregnancy).

1.4.6 For pregnant women with moderate-to-severe nausea and vomiting:

- consider intravenous fluids, ideally on an outpatient basis
- consider acupressure as an adjunct treatment.

1.4.7 Consider inpatient care if vomiting is severe and not responding to primary care or outpatient management. This will include women with hyperemesis gravidarum. For more information on managing hyperemesis gravidarum, see the Royal College of Obstetricians and Gynaecologists' guideline on the management of nausea and vomiting of pregnancy and hyperemesis gravidarum. Also see the section on venous thromboembolism.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on nausea and vomiting.

Full details of the evidence and the committee's discussion are in evidence review R: management of nausea and vomiting in pregnancy.

Heartburn

1.4.8 Give information about lifestyle and dietary changes to pregnant women with heartburn in line with the section on common elements of care in the NICE guideline on gastro-oesophageal reflux disease and dyspepsia in adults.

1.4.9 Consider a trial of an antacid or alginate for pregnant women with heartburn.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on heartburn.

Full details of the evidence and the committee's discussion are in evidence review S: management of heartburn in pregnancy.

Symptomatic vaginal discharge

1.4.10 Advise pregnant women who have vaginal discharge that this is common during pregnancy, but if it is accompanied by symptoms such as itching, soreness, an unpleasant smell or pain on passing urine, there may be an infection that needs to be investigated and treated.

1.4.11 Consider carrying out a vaginal swab for pregnant women with symptomatic vaginal discharge if there is doubt about the cause.

1.4.12 If a sexually transmitted infection is suspected, consider arranging appropriate investigations.

1.4.13 Offer vaginal imidazole (such as clotrimazole or econazole) to treat vaginal candidiasis in pregnant women.

1.4.14 Consider oral or vaginal antibiotics to treat bacterial vaginosis in pregnant women in line with the NICE guideline on antimicrobial stewardship.

For a short explanation of why the committee made the recommendations and how they might practice, see the rationale and impact section on symptomatic vaginal discharge.

Full details of the evidence and the committee's discussion are in evidence review T: management of symptomatic vaginal discharge in pregnancy.

Pelvic girdle pain

1.4.15 For women with pregnancy-related pelvic girdle pain, consider referral to physiotherapy services for:

- exercise advice **and/or**
- a non-rigid lumbopelvic belt.

For a short explanation of why the committee made the recommendation and how it might affect practice, see the rationale and impact section on pelvic girdle pain.

Full details of the evidence and the committee's discussion are in evidence review U: management of pelvic girdle pain in pregnancy.

Unexplained vaginal bleeding after 13 weeks

1.4.16 Offer anti-D immunoglobulin to women who present with vaginal bleeding after 13 weeks of pregnancy if they are:

- rhesus D-negative **and**
- at risk of isoimmunisation.

1.4.17 Refer pregnant women with unexplained vaginal bleeding after 13 weeks to secondary care for a review.

1.4.18 For pregnant women with unexplained vaginal bleeding after 13 weeks, assess whether to admit them to hospital, taking into account:

- the risk of placental abruption
- the risk of preterm delivery
- the extent of vaginal bleeding
- the woman's ability to attend secondary care in an emergency.

1.4.19 For pregnant women who present with unexplained vaginal bleeding, offer to carry out placental localisation by ultrasound if the placental site is not known.

1.4.20 For pregnant women with unexplained vaginal bleeding who are admitted to hospital, consider corticosteroids for fetal lung maturation if there is an increased risk of preterm birth within 48 hours. Take into account gestational age (see the section on maternal corticosteroids in the NICE guideline on preterm labour and birth).

1.4.21 Consider discussing the increased risk of preterm birth with women who have unexplained vaginal bleeding.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on unexplained vaginal bleeding after 13 weeks.

Full details of the evidence and the committee's discussion are in evidence review V: management of unexplained vaginal bleeding in pregnancy.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline.

Bonding and emotional attachment

Bonding is the positive emotional and psychological connection that the parent develops with the baby.

Emotional attachment refers to the relationship between the baby and parent, driven by innate behaviour and which ensures the baby's proximity to the parent and safety. Its development is a complex and dynamic process that is dependent on sensitive and emotionally attuned parent interactions supporting healthy infant psychological and social development and a secure attachment. Babies form attachments with a variety of caregivers but the first, and usually most significant of these, will be with the mother and/or father.

Continuity of carer

Having continuity of carer means that a trusting relationship can be developed between the woman and the healthcare professional who cares for her. Better Births, a report by the National Maternity Review, defines continuity of carer as consistency in the midwifery team (between 4 and 8 individuals) that provides care for the woman and her baby throughout pregnancy, labour and the postnatal period. A named midwife coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are met throughout the antenatal, intrapartum and postnatal periods.

For the purpose of this guideline, definition of continuity of carer in the Better Births report has been adapted to include not just the midwifery team but any healthcare team involved in the care of the woman and her baby. It emphasises the importance of effective information transfer between the individuals within the team. For more information, see the NHS Implementing Better Births: continuity of carer.

Partner

Partner refers to the woman's chosen supporter. This could be the baby's father, the woman's partner, family member or friend, or anyone who the woman feels supported by and wishes to involve in her antenatal care.

Shared decision making

Shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future, for example, through advance care planning. See the full definition in the NICE guideline on shared decision making. In line with NHS England's personalised care and support planning guidance: guidance for local maternity systems, in maternity services, this may be referred to as 'informed decision making'.

Structured fetal movement awareness packages

The structured fetal movement awareness package described in the Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM) trial consisted of:

- an e-learning education package for all clinical staff about the importance of a recent

change in the frequency of fetal movements and how to manage reduced fetal movements

- a leaflet given to pregnant women at 20 weeks of pregnancy to raise awareness of the importance of monitoring fetal movements and reporting reduced movements
- a structured management plan for hospitals following reporting of reduction in fetal movement including cardiotocography, measurement of liquor volume and a growth scan (umbilical artery doppler was encouraged if available).

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Hospitalisation of pregnant women with unexplained vaginal bleeding

What is the clinical and cost effectiveness of hospitalisation compared with outpatient management for pregnant women with unexplained vaginal bleeding?

For a short explanation of why the committee made this recommendation for research, see the rationale section on unexplained vaginal bleeding.

Full details of the evidence and the committee's discussion are in evidence review V: management of unexplained vaginal bleeding in pregnancy.

2 Medications for mild to moderate nausea and vomiting in pregnancy

What is the clinical and cost effectiveness of medication for women with nausea and vomiting in pregnancy?

For a short explanation of why the committee made this recommendation for research, see the rationale section on nausea and vomiting.

Full details of the evidence and the committee's discussion are in evidence review R: management of nausea and vomiting in pregnancy.

3 Models of antenatal care

What is the clinical and cost effectiveness of different models of antenatal care with varying numbers and times of appointment, and should different models be used for groups at risk of worse outcomes?

For a short explanation of why the committee made the recommendation for research about how to start antenatal care, see the rationale section on starting antenatal care.

Full details of the evidence and the committee's discussion are in evidence review F: accessing antenatal care.

For a short explanation of why the committee made the recommendation for research about the ideal number and timing of antenatal appointments, see the rationale section on antenatal appointments.

Full details of the evidence and the committee's discussion are in evidence review F: accessing antenatal care.

4 Identification of breech presentation

What is the clinical and cost effectiveness of routine ultrasound from 36+0 weeks compared with selective ultrasound in identifying breech presentation?

For a short explanation of why the committee made this recommendation for research, see the rationale section on breech presentation.

Full details of the evidence and the committee's discussion are in evidence review L: identification of breech presentation.

5 Management of severe nausea and vomiting

What is the clinical and cost effectiveness of corticosteroids for women with severe nausea and vomiting in pregnancy?

For a short explanation of why the committee made this recommendation for research, see the rationale section on nausea and vomiting.

Full details of the evidence and the committee's discussion are in evidence review R: management of nausea and vomiting in pregnancy.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

Starting antenatal care

Recommendations 1.1.1 to 1.1.3

Why the committee made the recommendations

No relevant evidence was identified and so the committee made the recommendations based on their knowledge and experience, and also made a recommendation for research about how to start antenatal care. The committee discussed the ways in which women should be able to access antenatal care, but agreed that the configuration details would depend on local arrangements.

The committee agreed that antenatal service planning should take into account women's needs and circumstances, and should not discriminate against, for example, a limited ability to use and access online services, limited skills in English language or in literacy, or not being registered with a GP surgery. The committee were aware that for some women in vulnerable situations or with limited English language skills, there may be a delay in accessing and starting antenatal care.

The booking appointment should occur by 10 weeks of pregnancy but the initial contact and referral might have happened several weeks earlier, so the committee agreed that the referral contact should include provision of early pregnancy information, for example, public health messages for the woman about folic acid supplementation or stopping smoking. It is also important to identify women with specific needs or risk factors early on so that appropriate care can be provided from the beginning.

The committee agreed that it is important to have the contact details for the woman's GP to ensure that information can be shared between primary care and maternity services so that care is provided according to the woman's individual needs, and to identify potential safeguarding issues.

How the recommendations might affect practice

There is variation in current practice in how women access antenatal care and the time between women's first contact with a healthcare professional and subsequent steps. Enabling women to start their antenatal care through various routes, including through school nurses, community centres or refugee hostels, may have some implications on resources; however, these should be outweighed by the benefits of timely antenatal care. The recommendations should improve timely access to antenatal care for women in various situations, and improve early recognition of specific needs and risk factors so that care can be planned.

Return to recommendations

Antenatal appointments

Recommendations 1.1.4 to 1.1.13

Why the committee made the recommendations

There was no new evidence to support changing from the existing recommended practice of women having their first antenatal (booking) appointment by 10+0 weeks.

Some women only contact, or are referred to, maternity services after 9+0 weeks. This 'late booking' may be particularly common among some socially vulnerable women or women with limited English language skills. Based on their knowledge and experience, the committee agreed that women who contact, or are referred to, maternity services after 9+0 weeks should have a booking appointment ideally within 2 weeks so that early pregnancy care, including information provision and screenings, can happen within the right timeframe. The committee agreed that it would be helpful to identify any underlying factors that may have led to the 'late booking' so that the woman's need for potential additional support or care can be considered and that any potential inequality and accessibility issues can be addressed.

There was no new evidence that led the committee to change from the existing recommended practice of arranging 10 appointments for nulliparous women and 7 appointments for parous women. Instead, the committee made a recommendation for research about the ideal number and timing of antenatal appointments, including consideration for groups at higher risk of adverse outcomes.

The evidence on women's experience and satisfaction in relation to the number of antenatal appointments was mixed, but the committee agreed the importance of being flexible to meet women's needs.

There was evidence that women who needed to use interpreters found the service to be unreliable and inconsistent, so the committee made a specific recommendation highlighting that interpreters should always be available when needed (including, for example, at scan appointments) and that they should be independent of the woman and not, for example, a family member or a friend.

There was good evidence that women value having the same midwife throughout their antenatal care, although the review did not look at the benefits and harms of continuity of carer in relation to clinical- and cost-effectiveness outcomes. The NHS England's report Better Births: improving outcomes of maternity services in England – a five year forward view for maternity care recommends continuity of carer by 1 midwife who is part of a small team of midwives based in the community, so that they can get to know the woman and provide support to her throughout pregnancy all the way to the postnatal period.

Various health professionals or providers may be involved throughout the pregnancy, and the committee emphasised the need for good communication between different health professionals and providers.

How the recommendations might affect practice

The timing of the booking appointment and the number of appointments reflects current clinical practice. The recommendation about women who do not have a booking appointment arranged by 9+0 weeks may lead to more women attending booking appointments before 11 weeks and it may also reduce how long it takes to secure a booking appointment. However, this may also be challenging for services to organise.

The recommendation about offering additional or longer antenatal appointments depending on need may lead to a small increase in the number of antenatal appointments, but this is likely to be negligible and potentially have benefits later on.

The recommendation on the use of interpreters is not new but is not well implemented in all units, so may involve a change in practice.

In current practice, providing continuity of carer can be difficult to achieve and there can

be significant resource implications; however, the recommendation reflects NHS England's recommendations.

The committee agreed that the recommendations would not result in a major change in practice but should reduce variation in practice and improve care for women.

Return to recommendations

Involving partners

Recommendations 1.1.14 to 1.1.16

Why the committee made the recommendations

The committee recognised that women's home and family circumstances vary, and it is up to the woman to decide who she may want to involve in her antenatal care. Involving partners is an important part of antenatal care, and the World Health Organization has emphasised the importance of engaging with partners during pregnancy, childbirth and postnatally. The committee discussed the impact that a partner's support, lack of support, or their wellbeing can have on the wellbeing of the pregnant woman. The committee recognised that the woman's partner is often also an expectant parent and being involved in the antenatal care, if the woman so wishes, can provide information and support for them as well.

The committee discussed that partners can face many types of barriers when engaging with antenatal services. There was good quality evidence on partners' views and experiences of antenatal care that showed that women appreciate being able to involve their partners in antenatal care, but that this can be difficult, for example, because of the partner's work patterns. Therefore, the committee agreed that the services should consider adapting when to offer antenatal classes (for example, in the evenings or at the weekends) to enable partners to be involved if the woman wishes.

Evidence showed that partners can feel like bystanders in appointments if, for example, there is no space for them to sit with their partner. The committee agreed ways that antenatal services could promote partner involvement. The committee agreed that partners are not always given information, including on how partners can support the woman during and after pregnancy, and the general pregnancy information that women receive.

Increased use of virtual platforms for appointments may also improve partners' involvement in antenatal care. For example, this could enable the partner to attend remotely if the woman has a face-to-face appointment, or for the couple to attend together if she has a video appointment. However, the committee recognised that evidence on video consultations and appointments was not reviewed for this guideline, and the benefits, harms and experiences related to them is important to consider when planning services. The committee also agreed that it is important to carefully assess any potential inequalities issues that could be associated with video appointments, for example, among people with sensory impairments or language barriers, minority groups, or in relation to access to devices or internet connection.

How the recommendations might affect practice

The committee agreed that the recommendations may increase and promote the involvement of partners, while respecting the woman's decisions. The recommendations are not expected to have a large resource impact or be difficult to implement although there may be some organisational changes needed to support making the timing of antenatal classes more flexible.

Return to recommendations

Taking and recording the woman's history

Recommendations 1.2.1 to 1.2.11

Why the committee made the recommendations

The recommendations were not developed by the usual NICE guideline systematic review process. A new evidence review was not considered necessary because the issues are covered by other NICE guidelines, or there is no clinical uncertainty or significant resource impact. Where there might be a potential limited resource impact, this could be justifiably offset by improved outcomes, avoidance of serious adverse outcomes or addressing inequalities. The recommendations were based on committee consensus on what is best practice, as well as other existing NICE guidelines.

Asking the woman about her past and present conditions and experiences in relation to her physical, obstetric, psychological, emotional and social health enables potential risk

factors to be identified and managed. The committee used their knowledge and experience to list the factors that should be discussed so that appropriate action can be taken, and care tailored to the woman's needs. For example, it is important to note which pharmacological and non-pharmacological remedies the woman uses so that current medication can be reviewed in light of pregnancy. It is important that women do not automatically stop using their regular medication without consultation. This discussion also allows for individualised advice on safe medicine use during pregnancy and can help with identifying any health issues that may have otherwise not come up.

The committee also agreed that it is important to discuss the woman's home and family situation and the available support she has. There may be issues that can impact on her wellbeing, for example, lack of support, illness in the family or a partner's substance use issues.

Sometimes there may be a reason to review the woman's previous medical records, for example, when her previous maternity care has been in a different organisation, she cannot recall details of a potentially significant issue, or the discussion somehow triggers a concern.

The committee agreed that healthcare professionals should be aware of the disproportionate maternal mortality and stillbirth rates among women and babies from black and Asian backgrounds and those living in deprived areas, as highlighted by the 2020 MBRRACE-UK reports on maternal mortality and perinatal mortality. This increased risk of death indicates that interventions to improve engagement, support and closer monitoring need to be explored. Future research could help understand the mechanisms underlying these disparities and what interventions could improve the outcomes. In general, action on the wider determinants of health, including different social, economic and environmental factors, is also needed to overcome such inequalities.

The committee agreed that domestic abuse puts both the woman and her baby at risk of harm, so it is important that all pregnant women are asked about it in a kind, sensitive way. Pregnancy can sometimes be a trigger for domestic abuse or existing domestic abuse can continue or worsen during pregnancy, so it is important that women feel that they can disclose it safely so that they can be supported, and interventions put in place if needed. Although partner involvement in antenatal care is welcome, it is also important to ensure that there is an opportunity to discuss domestic issues privately with the woman.

The committee recognised the need to identify women who have undergone female

genital mutilation (FGM) or whose unborn baby girl might be at risk of FGM so that appropriate safeguarding can take place. In the context of this guideline, this could be the pregnant woman, or the unborn baby when there is a family history or tradition of FGM. There is a mandatory duty to report suspected or known FGM in under 18s. The Department of Health and Social Care has produced a quick guide for healthcare professionals on FGM safeguarding and risk assessment, which includes information about countries where FGM is practised, and practical advice on how to start the conversation.

Identifying underlying cardiac problems is important because cardiovascular disease is the leading cause of death among women in the UK during and after pregnancy, according to 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 2016–18. Some women are at a higher risk of undiagnosed structural cardiac problems, such as women with a family history of cardiac abnormalities or women who were brought up in a country with a high incidence of rheumatic fever. Clinical assessment cannot identify all cardiac problems that cause maternal mortality, but it might pick up structural heart disease or concerns that warrant further investigations. Early identification of underlying cardiac conditions allows these women to receive appropriate care during their pregnancy, childbirth and postnatal period, and potentially avoid poor outcomes.

The committee also agreed the importance of information sharing between the maternity unit and the GP, and agreeing this with the woman. This is particularly important if the woman has self-referred (because the GP may be unaware of her pregnancy), and if women have a complex medical, psychological or social history (because different agencies may need to be involved in her and her baby's care).

Antenatal appointments are opportunities for continued monitoring and risk assessment on the health and wellbeing of the woman and her baby. They also allow for regular reassessments of women's antenatal care needs and plans.

How the recommendations might affect practice

The recommendations largely reflect current best practice. Clinical assessment for cardiac conditions is not always done for women who may be at an increased risk so this recommendation may change practice to some extent. The number of women this recommendation applies to is relatively small and the potentially life-saving benefit of this simple examination outweighs the potential cost and resource implications.

Return to recommendations

Examinations and investigations

Recommendations 1.2.12 to 1.2.17

Why the committee made the recommendations

Most of the issues are covered by national screening programmes or other NICE guidance, so no new evidence review was needed. The committee agreed, by consensus, any other recommendations where there is no clinical uncertainty or significant resource impact.

The timing of the ultrasound scans aligns with the NHS fetal anomaly screening programme.

It is important that women understand the potential implications of each of the tests being offered so that they have the opportunity to accept or decline.

How the recommendations might affect practice

The recommendations reflect current practice and no change in practice is expected.

Return to recommendations

Venous thromboembolism

Recommendations 1.2.18 to 1.2.20

Why the committee made the recommendations

The committee based the recommendations on the evidence on independent risk factors for venous thromboembolism in pregnancy, their knowledge and experience, and the NICE guideline on venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. The evidence on independent risk factors for venous thromboembolism during pregnancy did not assess the accuracy of tools used to measure the risk, so the committee recommended that tools should meet certain quality criteria. They agreed that an example of a tool that might be used is the risk assessment

tool in the Royal College of Obstetricians and Gynaecologists' green-top guideline on reducing the risk of venous thromboembolism during pregnancy (2015), which is commonly used in practice.

The committee highlighted some risk factors in the evidence review (blood type A or B, miscarriage after 10 weeks in the current pregnancy and history of previous blood transfusion) that are not always incorporated into commonly used venous thromboembolism tools. However, they agreed not to include them specifically in the recommendations because it could give a false impression that these factors were more important than others or lead to overtreatment.

The committee agreed that women assessed as being at an increased risk of venous thromboembolism should be offered referral to an obstetrician so that a risk management plan can be made, for example, starting thromboprophylaxis.

How the recommendation might affect practice

The recommendation reflects current practice and no change in practice is expected.

Return to recommendations

Gestational diabetes

Recommendations 1.2.21 and 1.2.22

Why the committee made the recommendations

Guidance on risk assessment for and identification of gestational diabetes is covered by the NICE guideline on diabetes in pregnancy.

How the recommendations might affect practice

The recommendation reflects current practice and no change in practice is expected.

Return to recommendations

Pre-eclampsia and hypertension in pregnancy

Recommendations 1.2.23 to 1.2.28

Why the committee made the recommendations

Guidance on risk assessment and risk reduction for pre-eclampsia is covered by the NICE guideline on hypertension in pregnancy. Although the guideline implies that pregnant women will be routinely tested for proteinuria, it does not explicitly recommend this. Therefore, the committee agreed that, in line with current practice, urine testing for proteinuria should be offered at every routine face-to-face appointment.

There was little evidence on the setting and technique for monitoring blood pressure during pregnancy, so the committee made the recommendations based on their knowledge and experience and existing NICE guidance. The committee were aware that the British and Irish Hypertension Society lists blood pressure measurement devices validated for use in pregnancy. This has also been noted in the NICE guideline on hypertension in adults.

The committee agreed that monitoring blood pressure and testing for proteinuria at every routine face-to-face antenatal appointment enables hypertension and pre-eclampsia to be identified and treated early, which is important because they can have severe consequences.

Guidance on care for pregnant women with gestational or chronic hypertension is covered by the NICE guideline on hypertension in pregnancy.

How the recommendations might affect practice

The recommendation reflects current practice and no change in practice is expected.

Return to recommendations

Monitoring fetal growth and wellbeing

Recommendations 1.2.29 to 1.2.35

Why the committee made the recommendations

Risk assessment starting in early pregnancy enables increased monitoring of babies who are at an increased risk of fetal growth restriction, which is associated with fetal morbidity and mortality. The committee were aware of available risk assessment tools, such as those in the Royal College of Obstetricians and Gynaecologists' guideline on the investigation and management of the small-for-gestational-age fetus or the NHS saving babies' lives care bundle version 2.

Evidence showed that ultrasound scans and symphysis fundal height measurement do not accurately predict a baby being born small or large for gestational age. However, the committee agreed that the current routine practice of using symphysis fundal height measurement to monitor fetal growth should be used, because it is a simple and low-cost intervention and can alert to further investigations when concerns arise about the baby being either larger or smaller than expected for gestational age. When the symphysis fundal height measurement is large for gestational age, ultrasound scans could be used to assess the size of the baby and the volume of amniotic fluid. Small-for-gestational-age babies are at an increased risk of perinatal mortality and morbidity; therefore, when this is suspected, further investigations should be done to monitor the growth and wellbeing of the baby, taking into consideration the full clinical picture.

The committee were aware that many women may request routine ultrasound scans in late pregnancy, but available evidence showed no benefit from routine ultrasound in late pregnancy (from 28 weeks) for uncomplicated singleton pregnancies. However, the absence of effect found in the evidence does not mean that there is definitely no effect. There was also no evidence on maternal anxiety in relation to routine ultrasound scanning. The committee were in favour of research on this in the future; however, a recommendation for research was not prioritised because there is a good amount of evidence on other key outcomes.

The committee were aware that cases of stillbirth have been linked to reduced fetal movements. Therefore, structured fetal movement awareness packages have been trialled. Evidence on the use of a structured fetal movement awareness package, such as the one described in the UK trial Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM), did not detect a reduction in stillbirths or perinatal mortality but did find that there were more interventions at birth, including more caesarean births and inductions of labour, and fewer spontaneous vaginal births. Another study from Sweden compared giving a leaflet to pregnant women teaching them a method of being aware of

fetal movements, with usual care. No clinically important benefits or harms were detected, including no difference in perinatal mortality, although there was a small, but statistically significant, reduction in births after 41+6 weeks and fewer caesarean births. Health economic evaluation did not establish cost effectiveness for either of these structured awareness packages.

Although the available evidence did not support the use of structured packages, the committee agreed that fetal movements should be discussed routinely and women's concerns should be taken seriously. The committee agreed that there is no agreed definition of normal fetal movements. Discussing the topic of babies' movements in the womb and how they change throughout the pregnancy can help women recognise changes to their own baby's movement patterns. When there are concerns, an assessment of the woman's wellbeing and the baby's wellbeing and size should be done.

How the recommendations might affect practice

The recommendations on fetal growth monitoring largely reflect current practice, although in some maternity units it is common to offer women with uncomplicated singleton pregnancies ultrasound scans after 28 weeks to monitor the baby, so there might be a change of practice for these units and some potential cost savings. On the other hand, there may be some more scans due to suspected large for gestational age.

Current practice for managing reduced fetal movements is to follow the NHS saving babies' lives care bundle version 2. The recommendations in this guideline similarly emphasise the importance of recognising and reporting concerns on fetal movements and acting on those concerns by assessing the woman and the baby.

Return to recommendations

Breech presentation

Recommendations 1.2.36 to 1.2.38

Why the committee made the recommendations

There was not enough evidence to support routine ultrasound at 36+0 weeks to 39+0 weeks to identify breech presentation, so the committee did not change the current

standard practice of offering abdominal palpation with selective ultrasound when breech is suspected.

Because of the lack of evidence, the committee made a recommendation for research to compare routine ultrasound scans from 36+0 weeks with selective ultrasound scans.

In the case of breech presentation, the committee agreed that a discussion about the different options and their potential benefits, harms and implications is needed to ensure an informed decision. External cephalic version is standard practice for managing breech presentation in uncomplicated singleton pregnancies at or after 36+0 weeks. Head-down vaginal birth is preferred by many women and the evidence suggests that external cephalic version is an effective way to achieve this.

How the recommendations might affect practice

The recommendations reflect current clinical practice and no change in practice is expected.

Return to recommendations

Communication – key principles

Recommendations 1.3.1 to 1.3.6

Why the committee made the recommendations

The committee agreed that the key principles of care in the antenatal period are to listen to women and be responsive to their needs, in line with the findings of the Ockenden report on maternity services at the Shrewsbury and Telford hospital NHS trust, and to enable women to make informed decisions about their care, in line with the Montgomery ruling. The committee emphasised that women should be supported in their decision making even when their preferences and values differ from those of the healthcare professionals.

The evidence did not show a particular benefit from any one specific approach to giving information, although 1 study found that supplementing information provided face-to-face with online information increased knowledge. The committee based the recommendations

on their knowledge and experience.

The committee agreed that information should meet the needs of the woman, for example, taking into account any language barriers, learning disabilities or other needs. Most antenatal care information is given in a one-to-one or couple discussion. Offering other formats to supplement this can help improve understanding and engagement, including written materials and group discussions in antenatal classes or, in some cases, group antenatal appointments.

There was evidence that women value information that is relevant to their own circumstances. The committee agreed that healthcare professionals should explore the level and accuracy of the woman's (and her partner's) existing knowledge and understanding of the topic. The committee discussed the importance of allowing sufficient time for discussions.

How the recommendations might affect practice

The recommendations largely reflect current practice.

Return to recommendations

Information about antenatal care

Recommendations 1.3.7 to 1.3.19

Why the committee made the recommendations

The committee agreed, based on the evidence and their knowledge and experience, that if women are given information about antenatal care, their schedule of appointments and what happens at different appointments and stages of pregnancy, they are more likely to be engaged, follow advice and share their concerns with healthcare professionals.

There was no evidence identified to inform the timing of information provision, but the committee agreed that it is important to have a staged approach and cover topics relevant to each stage of pregnancy.

The first antenatal (booking) appointment is an opportunity to discuss and share

information about various practical issues related to pregnancy and antenatal care so that the woman knows what to expect and how to get support. The evidence showed that partners also value practical information throughout the pregnancy. For example, in relation to safe use of medicines in pregnancy, the committee were aware of the UK Teratology Information Service's information resources on best use of medicines in pregnancy (bumps).

The evidence suggested that women want information on how behavioural factors, such as smoking, alcohol, diet and physical activity may affect them and their baby's health. The evidence also highlighted how emotional these topics could be for women and that women may feel judged or patronised. The committee agreed that it is important to have these discussions in a sensitive manner that supports individual women. Guidance on all these issues is covered by other NICE guidelines or government documents.

The committee recognised that pregnant women and their partners often look for information and support from various sources, such as websites, and not all of them are necessarily evidence-based, so signposting to trusted resources may be helpful.

There was some evidence that women and their partners valued information and discussion around the transition to parenthood, and the changes that pregnancy and becoming a parent will bring to their life and relationship. The committee were aware of various available resources that could be helpful for parents, particularly new parents.

The evidence showed that women want information on their options for giving birth. The committee agreed that these discussions should start, at the latest, around the start of the third trimester, depending on the woman's preferences and circumstances. The committee agreed, in line with the Montgomery ruling, that discussing the implications, benefits and risks is fundamental to making shared and informed decisions. Guidance on making decisions about place of birth, mode of birth and prolonged pregnancy are also covered by other NICE guidelines.

Considering the amount of new information given at the beginning of antenatal care, discussions around practical aspects related to labour, childbirth and postnatal care are often more appropriate later on in pregnancy. There was some evidence that healthcare professionals thought that providing information on emotional attachment and bonding could improve women's confidence and increase their preparedness for birth. Further recommendations about promoting emotional attachment and bonding, as well as planning and managing infant feeding, are covered by the NICE guideline on postnatal care.

How the recommendations might affect practice

The recommendations will improve consistency of care and reinforce best practice.

Return to recommendations

Antenatal classes

Recommendations 1.3.19 to 1.3.21

Why the committee made the recommendations

Evidence among nulliparous women showed that women who went to antenatal classes were more likely to have their cervix dilated by 3 cm or more on admission to labour. A dilated cervix on admission may reduce the need for interventions. This may indicate that women who attended antenatal classes have better coping strategies and the confidence to deal with pain at home in the early stages of labour. There was no evidence about the most effective content for antenatal classes, so the committee made the recommendations based on their experience.

The committee recognised that there may be multiparous women who could also particularly benefit from antenatal classes, so providing them for these women should be considered.

The committee recognised that some groups of women may be less likely to attend antenatal classes (for example, some women from low income or disadvantaged backgrounds or minority ethnic groups, or those for whom English is not their first language). The committee agreed that in order to increase engagement with antenatal classes, service providers should ensure that classes are accessible, welcoming and adapted to meet the needs of local communities.

How the recommendations might affect practice

The recommendations reflect current practice. However, adapting classes to the needs of the local communities might involve some reorganising of practices.

Return to recommendations

Peer support

Recommendations 1.3.22 and 1.3.23

Why the committee made the recommendations

The evidence showed that peer support could offer helpful and valuable care and guidance during the antenatal period. There was evidence among women from particular subpopulations, such as migrant women, women of lower socioeconomic status, women with intellectual disabilities, or younger women, and the committee agreed that peer support groups among women in similar circumstances might be particularly helpful.

The committee discussed that peer support, including group peer support, volunteer peer support, doula support and online support, is usually provided through 'third sector' services, and they agreed that healthcare professionals should give women information about how to contact local and national services. Although there was little evidence on partners' experiences of peer support, in the committee's experience, some partners find peer support services for partners helpful.

How the recommendations might affect practice

The recommendations reflect current best practice.

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Sleep position

Recommendations 1.3.24 and 1.3.25

Why the committee made the recommendations

The evidence suggested that there is an increased risk of stillbirth and babies being born small for gestational age after 28 weeks if women fall asleep on their backs. The committee agreed that there is some uncertainty about this risk because the evidence was from relatively small studies whose design made it difficult to assume that sleep position caused the adverse outcomes. The committee recognised that further research is unlikely because conducting sufficiently powered prospective cohort studies is not

feasible given the relatively low incidence of stillbirth (1 in every 244 births in England and Wales according to 2018 Office for National Statistics [ONS] data). The committee also noted that not all the included studies used the same definition of stillbirth and that only 1 study reported data according to whether the stillbirth occurred at term or at preterm. On balance, the committee agreed that the evidence was strong enough to advise women to try to avoid going to sleep on their back after 28 weeks.

The committee knew from their experience that providing practical advice about risk reduction is extremely important for pregnant women. They discussed reassuring women about sleep positions, aids that could make it easier for pregnant women not to go to sleep on their backs and maintain this position when sleeping, for example, by using pillows.

The committee also agreed that the reason for this advice should be explained, and they recognised the potential anxiety and feelings of guilt that women may experience, for example, if they wake up on their backs.

How the recommendations might affect practice

Healthcare professionals may need to spend more time talking to women about sleep position in pregnancy, but the recommendations are not expected to have a significant cost or resource impact.

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Nausea and vomiting

Recommendations 1.4.1 to 1.4.7

Why the committee made the recommendations

Nausea and vomiting in pregnancy can affect daily functioning and quality of life, and can cause significant worry and upset. Based on their knowledge and experience, the committee agreed that it is important to reassure pregnant women who experience mild-to-moderate nausea and vomiting that these are common symptoms in early pregnancy and will usually settle later in the second trimester.

However, the committee recognised that many pregnant women expect nausea and

vomiting in pregnancy and might even tolerate significant symptoms and try various self-help approaches before seeking medical advice. It is therefore important to take it seriously when women do seek help.

Some women prefer to use non-pharmacological treatments whereas others may prefer pharmacological treatments, so both options are recommended.

There was some evidence that ginger is effective in treating mild-to-moderate nausea and vomiting in pregnancy compared with placebo, and this may be an option particularly for women who want to try a non-pharmacological option.

There was evidence on a wide variety of pharmacological treatments, many of which are commonly used in current practice. The evidence on the medicines varied in quality and for some medicines, no evidence was found. Metoclopramide hydrochloride was supported by good quality evidence showing that it was effective in improving symptoms. Ondansetron was also found to be effective in improving symptoms. A combination drug with pyridoxine and doxylamine is currently the only drug licensed for this indication, but the evidence is very old and of low quality and did not show a convincing effect on symptom improvement. Evidence on histamine H1 receptor antagonists was of very low quality and not particularly convincing. Studies on pyridoxine hydrochloride showed differing results, with larger trials showing no improvement in symptoms. No evidence was identified on the effectiveness of cyclizine hydrochloride alone in pregnant women, so the committee made a recommendation for research on the effectiveness of medication for women with nausea and vomiting in pregnancy.

The treatment options have different advantages and disadvantages, including effectiveness in relieving symptoms, safety and other considerations, which have been summarised in a table to help with decision making. The committee used information available from the British National Formulary (BNF), the UK Teratology Information Service monographs and patient information leaflets, and the manufacturers' summaries of product characteristics to inform women about the potential effects on the baby. The committee recognised that women are often concerned about the possible adverse effects of medicines on the baby and that these should be discussed in the context of understanding the small risk of adverse outcomes unrelated to medicine use.

The evidence for treating the more severe form of nausea and vomiting in pregnancy did not generally support any different treatment options from those used for mild and moderate nausea and vomiting in pregnancy. An exception was for acupressure combined

with standard care where the evidence showed benefits in relieving symptoms in women with moderate-to-severe nausea and vomiting in pregnancy, which was not shown for women with mild and moderate nausea and vomiting. Therefore, the committee recommended that acupressure could be considered for women with moderate-to-severe nausea and vomiting as an additional treatment.

No recommendation was made on the use of corticosteroids as a treatment for severe nausea and vomiting in pregnant women because, despite research in this area, no evidence was found to support its use. The committee discussed that although corticosteroids have well-known harms, the benefits can outweigh them so that some units use corticosteroids in severe cases of nausea and vomiting in pregnancy, and so a recommendation for research on the effectiveness of corticosteroids for women with severe nausea and vomiting in pregnancy was made.

Some women with moderate-to-severe nausea and vomiting in pregnancy might need intravenous fluids. The evidence showed no difference in most outcomes between offering intravenous fluids in an inpatient or outpatient setting. Offering them to an outpatient is less expensive, reduces time spent in hospital and, in the committee's experience, is generally preferred by women. Inpatient care may be needed when severe nausea and vomiting persists despite treatment. Hyperemesis gravidarum can have serious harmful consequences, and treatment and care in hospital may be needed. It should be noted that this guideline only covers treatments to manage nausea and vomiting in pregnancy, and comprehensive management of hyperemesis gravidarum, which may include nutritional interventions, is not covered by this guideline on routine antenatal care.

How the recommendations might affect practice

The treatment options are all used in current practice but there may be a change in practice in encouraging shared decision making for different options. This may mean that those prescribing medicines may need to spend more time discussing the options with the woman.

An increase in giving intravenous fluids as an outpatient service instead of an inpatient service could bring cost savings.

Return to recommendations

Heartburn

Recommendations 1.4.8 and 1.4.9

Why the committee made the recommendations

There was no evidence on whether giving lifestyle and diet information to pregnant women with heartburn is effective, but the committee agreed, based on their own knowledge and experience, that it may help. This is supported by guidance for the general adult population in the NICE guideline on gastro-oesophageal reflux disease and dyspepsia.

The committee recommended considering either antacid or alginate therapy for women with heartburn in pregnancy because there is evidence that they are equally effective. These medicines are available over the counter. Because the studies examined various antacid and alginate remedies, the committee agreed that they could not make a more specific recommendation.

The committee did not make any recommendations about acupuncture or proton pump inhibitors (PPIs) because, although there was some evidence that acupuncture is effective in alleviating heartburn and that PPI use in the first trimester is not harmful to the baby, it was of very low quality and not good enough to support recommending them to be used routinely. In addition, there was no evidence on H2 receptor antagonist (H2RA) therapy to treat heartburn in pregnancy.

How the recommendations might affect practice

The recommendations reflect current clinical practice.

Return to recommendations

Symptomatic vaginal discharge

Recommendations 1.4.10 to 1.4.14

Why the committee made the recommendations

There was limited evidence on the effectiveness of treatments for symptomatic vaginal

discharge in pregnant women, so the committee used their knowledge and clinical experience to make the recommendations. The committee agreed that some women can find an increase in vaginal discharge distressing or uncomfortable, so it is important to reassure women that it is a normal feature of pregnancy. However, women should also be made aware of the symptoms and signs of infection that may need further action, because there is a small chance that some infections could lead to complications.

Candidiasis (thrush) is often an easily identifiable cause of symptomatic vaginal discharge and may not need a formal investigation. However, if there is doubt about the cause, a vaginal swab could be used. It is important that possible sexually transmitted infections are appropriately investigated so that they can be treated, because they could have an impact on the baby.

The evidence on antifungal treatment to treat symptomatic vaginal discharge because of vaginal candidiasis was very limited, imidazole being the only drug class being studied. However, imidazole (for example, clotrimazole or econazole) was consistently shown to be effective.

The evidence on the benefits and harms of antibiotics to treat symptomatic vaginal discharge due to bacterial vaginosis was also very limited. There was only evidence on oral amoxicillin (which is not commonly prescribed in current practice for this indication) and oral metronidazole. The committee were aware of evidence among asymptomatic populations that antibiotics are effective in treating the underlying infection, but the committee agreed that it cannot be assumed that they would be effective in relieving symptomatic vaginal discharge. The committee noted that it is common practice to prescribe vaginal rather than oral antibiotics for this indication – in particular, clindamycin or metronidazole. Combining this with their knowledge and experience, they recommended that either oral or vaginal antibiotics could be considered. The NICE guideline on antimicrobial stewardship gives guidance on good practice in prescribing antimicrobials.

No evidence was identified on the effectiveness of metronidazole to treat symptomatic vaginal discharge because of vaginal trichomoniasis, therefore no recommendations were made.

How the recommendations might affect practice

The committee agreed that the recommendations will reinforce current best practice and

standardise care.

Return to recommendations

Pelvic girdle pain

Recommendation 1 4.15

Why the committee made the recommendation

There was evidence of varying quality from several randomised controlled trials that exercise advice from a physiotherapist may reduce pain intensity and pelvic-related functional disability. The committee recommended referral to physiotherapy services rather than to a physiotherapist because, in some cases, information and advice could be given over the telephone or in an email or letter rather than in a face-to-face appointment.

Moderate quality evidence from 1 randomised controlled trial showed that a non-rigid lumbopelvic belt together with general information about anatomy, body posture and ergonomic advice reduced pelvic girdle pain intensity, compared with exercise advice and information, and information only. However, it did not have an impact on functional status in daily activities. No evidence was identified about adverse effects of using a lumbopelvic belt. Providing a non-rigid lumbopelvic belt was also found to be cost effective based on an economic evaluation, but because the clinical evidence base was limited, the committee agreed not to make a strong recommendation.

The committee agreed that there was not enough evidence to show that manual therapy alone had any benefits for women with pelvic girdle pain, so did not make a recommendation. The committee agreed that the evidence for acupuncture to treat pelvic girdle pain was mixed, of poor quality and therefore not adequate enough to justify a recommendation that would have a substantial resource impact.

How the recommendation might affect practice

Current practice for pregnancy-related pelvic girdle pain is to offer analgesics (for example, paracetamol) and provide information about lifestyle and health changes. Some hospitals also have access to physiotherapy services. Providing a lumbopelvic belt is not current practice in all units, so the committee recognised that the recommendation may

have cost implications. However, health economic modelling showed that it is cost effective even if women are referred for physiotherapy. The recommendation may increase the number of pregnant women seeking referral to physiotherapy services.

Return to recommendation

Unexplained vaginal bleeding after 13 weeks

Recommendations 1.4.16 to 1.4.21

Why the committee made the recommendations

There was very little evidence, so the committee used their knowledge and experience to make recommendations. They took into account the risks associated with a delay in assessing and treating unexplained vaginal bleeding in pregnancy, the possibility that anti-D injections may be needed for women who are rhesus D-negative, the need to exclude a low-lying placenta (placenta praevia) and that corticosteroids may be needed if there is a risk of preterm birth.

The committee agreed that a review in secondary care is needed when unexplained vaginal bleeding occurs after 13 weeks of pregnancy. Evidence on the effectiveness of hospitalisation was limited, with only 1 retrospective study that showed no difference in the number of fetal deaths whether women were admitted to hospital or discharged on the day they presented. Because of limited evidence, the committee made a recommendation for research on the effectiveness of hospitalisation compared with outpatient management for pregnant women with unexplained vaginal bleeding.

The committee agreed that hospitalisation should be considered for monitoring, administering corticosteroids and neonatal unit care if the baby is born preterm. Discussion with the woman about the possibility of preterm birth may also be helpful.

How the recommendations might affect practice

The recommendations reflect current practice.

Return to recommendations

Context

Around 660,000 women give birth in England and Wales each year. The antenatal period is an excellent opportunity to not only provide support and information to women (and their families) about pregnancy, birth and the postnatal period, but also to assess their risk of complications. Even in fit and healthy women, concerns and complications can still arise, and good quality antenatal care is vital to identify and deal with potential problems and reduce the chance of poor outcomes for both the woman and the baby.

Antenatal service delivery and provision of care have changed over time and this guideline updates and replaces the version of the NICE guideline on antenatal care (first published in 2008).

This guideline covers routine antenatal care for all women. However, it does not cover specialised care for women with underlying medical conditions or obstetric complications (once diagnosed) but refers to other NICE guidelines.

This guideline covers the organisation and delivery of antenatal care, in particular, how to initially access antenatal care and antenatal appointments, and the involvement of partners in antenatal care. Routine care and monitoring during pregnancy is covered and the guideline makes references to other guidance on risk assessment and screening. This guideline also covers providing information and support during antenatal care, and managing some of the common problems during pregnancy.

Throughout the development of this guideline, the committee has considered how antenatal care could be made accessible, fair and high quality for all women, regardless of their background or situation.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on pregnancy.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

August 2021: This guideline updates and replaces NICE guideline CG62 (published March 2008).

Minor changes since publication

December 2025: We amended recommendation 1.3.8 to add that information on immunisation for respiratory syncytial virus (RSV) should be given at the first antenatal (booking) appointment (and later if appropriate).

May 2025: We amended a column heading in table 1 to clarify that it only covers notable safety concerns relating to the use of some pharmacological treatments in pregnancy.

March 2025: We updated links to relevant technology appraisal guidance in the section on examinations and investigations.

December 2024: We added a link to the NICE guideline on end of life care for adults. See the surveillance report for further details.

October 2023: We updated the link to the NICE guideline on intrapartum care.

August 2023: In our recommendations on managing nausea and vomiting we linked to information on hyperemesis gravidarum in the Royal College of Obstetricians and Gynaecologists' guideline on the management of nausea and vomiting of pregnancy and hyperemesis gravidarum.

December 2021: We have added links to our guideline on pelvic floor dysfunction (recommendation 1.3.12).

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