NICE National Institute for Health and Care Excellence

NICE Pathways

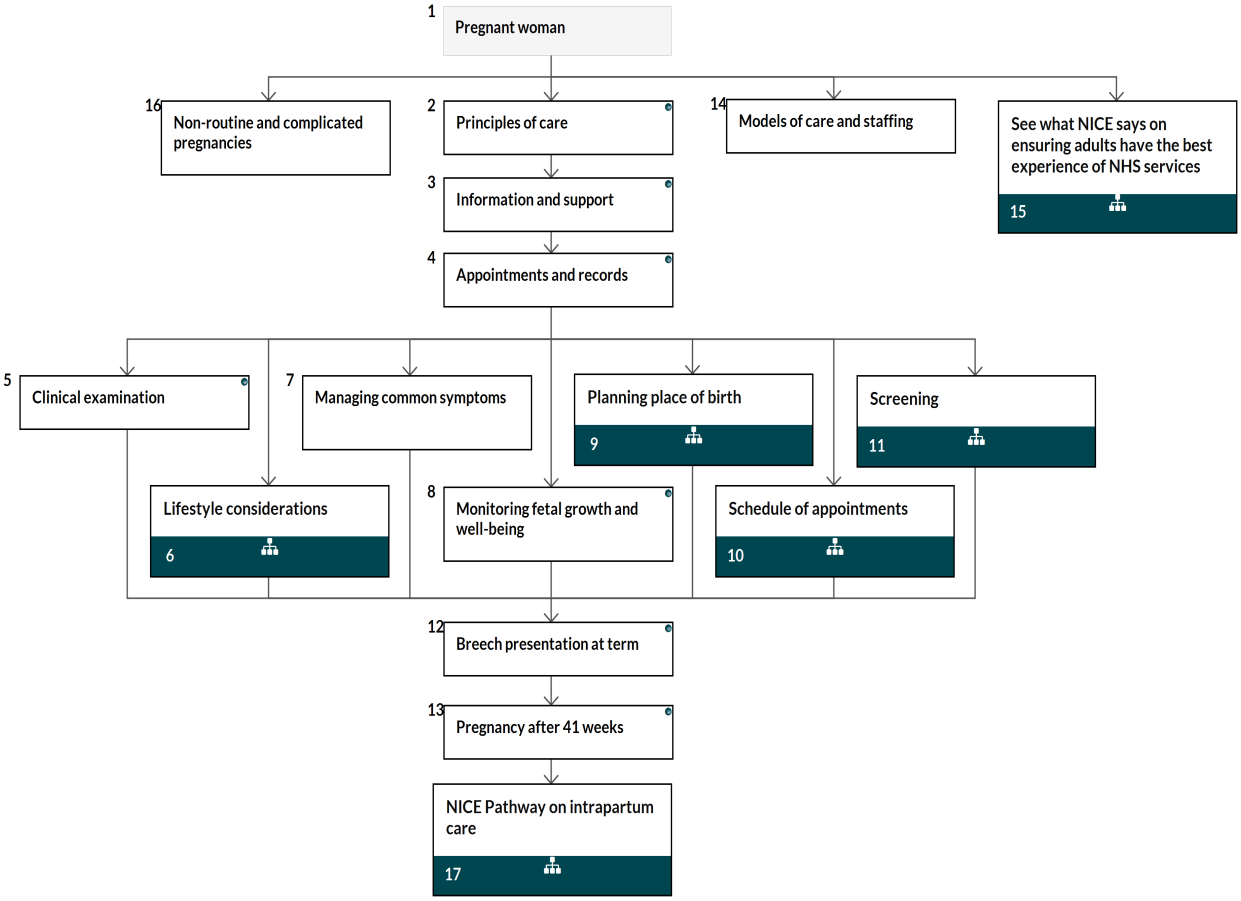
Antenatal care for uncomplicated pregnancies overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/antenatal-care-for-uncomplicated-pregnancies
NICE Pathway last updated: 24 September 2019

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Pregnant woman

No additional information

2 Principles of care

Antenatal care should be provided by a small group of healthcare professionals with whom the woman feels comfortable. There should be continuity of care throughout the antenatal period.

A system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified.

Antenatal care should be readily and easily accessible to all pregnant women and should be sensitive to the needs of individual women and the local community.

The environment in which antenatal appointments take place should enable women to discuss sensitive issues such as domestic violence, sexual abuse, psychiatric illness and recreational drug use.

Pregnant women should be offered opportunities to attend participant-led antenatal classes, including breastfeeding workshops.

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

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Antenatal care quality standard

1. Services – access to antenatal care
2. Services – continuity of care
4. Risk assessment – body mass index
6. Risk assessment – gestational diabetes

8. Risk assessment – intermediate risk of venous thromboembolism

9. Risk assessment – high risk of venous thromboembolism

3 Information and support

Antenatal information should be given to pregnant women according to the following schedule.

- At the first contact with a healthcare professional:
  - folic acid supplementation
  - food hygiene, including how to reduce the risk of a food-acquired infection
  - lifestyle advice, including smoking cessation, and the implications of recreational drug use and alcohol consumption in pregnancy
  - all antenatal screening, including screening for haemoglobinopathies, the anomaly scan and screening for Down's syndrome, as well as risks and benefits of the screening tests.
- At booking (ideally by 10 weeks):
  - how the baby develops during pregnancy
  - nutrition and diet, including vitamin D supplementation for women at risk of vitamin D deficiency, and details of the Healthy Start programme
  - exercise, including pelvic floor exercises
  - place of birth (see planning place of birth)
  - pregnancy care pathway
  - breastfeeding, including workshops
  - participant-led antenatal classes
  - further discussion of all antenatal screening
  - discussion of mental health issues (see what NICE says on antenatal and postnatal mental health)
- Before or at 36 weeks:
  - breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF Baby Friendly Initiative
  - preparation for labour and birth, including information about coping with pain in labour and the birth plan
  - recognition of active labour
  - care of the new baby
  - vitamin K prophylaxis

- newborn screening tests
- postnatal self-care
- awareness of 'baby blues' and postnatal depression.

- At 38 weeks:
  - options for management of prolonged pregnancy.

See also schedule of appointments for further information on antenatal appointments.

This can be supported by information such as 'The pregnancy book' (Department of Health 2007) and the use of other relevant resources such as UK National Screening Committee publications and the MIDIRS information leaflets.

Information should be given in a form that is easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities, and to pregnant women who do not speak or read English.

Information can also be given in other forms such as audiovisual or touch-screen technology; this should be supported by written information.

Pregnant women should be offered information based on the current available evidence together with support to enable them to make informed decisions about their care. This information should include where they will be seen and who will undertake their care.

At each antenatal appointment, healthcare professionals should offer consistent information and clear explanations, and should provide pregnant women with an opportunity to discuss issues and ask questions.

Pregnant women should be informed about the purpose of any test before it is performed. The healthcare professional should ensure the woman has understood this information and has sufficient time to make an informed decision. The right of a woman to accept or decline a test should be made clear.

Information about antenatal screening should be provided in a setting where discussion can take place; this may be in a group setting or on a one-to-one basis. This should be done before the booking appointment.

Information about antenatal screening should include balanced and accurate information about the condition being screened for.

See also what NICE says on maternal and child nutrition.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Antenatal care quality standard

1. Services – access to antenatal care

Nutrition: improving maternal and child nutrition quality standard

1. Healthy eating in pregnancy

Intrapartum care

1. Choosing birth setting

4 Appointments and records

Appointments

A schedule of antenatal appointments should be determined by the function of the appointments. For a woman who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate. For a woman who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate.

Early in pregnancy, all women should receive appropriate written information about the likely number, timing and content of antenatal appointments associated with different options of care and be given an opportunity to discuss this schedule with their midwife or doctor.

Each antenatal appointment should be structured and have focused content. Longer appointments are needed early in pregnancy to allow comprehensive assessment and discussion. Wherever possible, appointments should incorporate routine tests and investigations to minimise inconvenience to women.

NICE has written information for the public on antenatal care for uncomplicated pregnancies.

See also schedule of appointments for further information on antenatal appointments.

See what NICE says on risk assessment for diabetes in pregnancy.

Records

Structured maternity records should be used for antenatal care.

Maternity services should have a system in place whereby women carry their own case notes.

A standardised, national maternity record with an agreed minimum data set should be developed and used. This will help healthcare professionals to provide the recommended evidence-based care to pregnant women.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

Antenatal care quality standard

1. Services – access to antenatal care

3. Services – record keeping

5 Clinical examination

Weight and BMI

Maternal weight and height should be measured at the booking appointment, and the woman's BMI should be calculated (weight [kg]/height[m^2]).

Repeated weighing during pregnancy should be confined to circumstances in which clinical management is likely to be influenced.

See what NICE says on obesity.

Gestational age assessment

Pregnant women should be offered an early ultrasound scan between 10 weeks days and 13 weeks 6 days to determine gestational age and to detect multiple pregnancies. This will ensure consistency of gestational age assessment and reduce the incidence of induction of labour for prolonged pregnancy.

Crown–rump length measurement should be used to determine gestational age. If the crown–rump length is above 84 mm, the gestational age should be estimated using head circumference.

Breast examination

Routine breast examination during antenatal care is not recommended for the promotion of postnatal breastfeeding.

Pelvic examination

Routine antenatal pelvic examination does not accurately assess gestational age, nor does it accurately predict preterm birth or cephalopelvic disproportion. It is not recommended.

Female genital mutilation

Pregnant women who have had female genital mutilation should be identified early in antenatal care through sensitive enquiry. Antenatal examination will then allow planning of intrapartum care.

Domestic violence

Healthcare professionals need to be alert to the symptoms or signs of domestic violence and women should be given the opportunity to disclose domestic violence in an environment in which they feel secure.

See what NICE says on domestic violence and abuse and pregnancy and complex social factors: service provision.

Mental disorders

For information on the assessment and management of mental health problems in women up to 1 year after childbirth see what NICE says on antenatal and postnatal mental health.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Antenatal care quality standard

4. Risk assessment – body mass index

6 Lifestyle considerations

See Antenatal care for uncomplicated pregnancies / Antenatal care for uncomplicated pregnancies: lifestyle considerations

7 Managing common symptoms

Nausea and vomiting

Women should be informed that most cases of nausea and vomiting in pregnancy will resolve spontaneously within 16 to 20 weeks and that nausea and vomiting are not usually associated with a poor pregnancy outcome. If a woman requests or would like to consider treatment, the following interventions appear to be effective in reducing symptoms:

- non-pharmacological:
  - ginger
  - P6 (wrist) acupressure
- pharmacological:
  - antihistamines.

Information about all forms of self-help and non-pharmacological treatments should be made available for pregnant women who have nausea and vomiting.

NICE has published an evidence summary on doxylamine/pyridoxine (Xonvea) for treating nausea and vomiting of pregnancy.

NICE has published a clinical knowledge summary on nausea and vomiting in pregnancy. This practical resource is for primary care professionals (it is not formal NICE guidance).

Dyspepsia

Women who present with symptoms of heartburn in pregnancy should be offered information regarding lifestyle and diet modification.

Antacids may be offered to women whose heartburn remains troublesome despite lifestyle and diet modification.

NICE has published a clinical knowledge summary on pregnancy-associated dyspepsia.

Constipation

Women who present with constipation in pregnancy should be offered information regarding diet modification, such as bran or wheat fibre supplementation.

NICE has published a clinical knowledge summary on constipation, and explains how to manage it for pregnant or breastfeeding women.

Haemorrhoids

In the absence of evidence of the effectiveness of treatments for haemorrhoids in pregnancy, women should be offered information concerning diet modification. If clinical symptoms remain troublesome, standard haemorrhoid creams should be considered.

Varicose veins

Women should be informed that varicose veins are a common symptom of pregnancy that will not cause harm and that compression stockings can improve the symptoms but will not prevent varicose veins from emerging.

For more information see what NICE says on pregnant women with varicose veins.

Vaginal discharge

Women should be informed that an increase in vaginal discharge is a common physiological change that occurs during pregnancy. If it is associated with itch, soreness, offensive smell or pain on passing urine there may be an infective cause and investigation should be considered.

A 1-week course of a topical imidazole is an effective treatment and should be considered for vaginal candidiasis infections in pregnant women.

The effectiveness and safety of oral treatments for vaginal candidiasis in pregnancy are uncertain and these treatments should not be offered.

Backache

Women should be informed that exercising in water, massage therapy and group or individual back care classes might help to ease backache during pregnancy.

See what NICE says on medicines optimisation.

8 Monitoring fetal growth and well-being

Symphysis–fundal height should be measured and recorded at each antenatal appointment from 24 weeks.

Ultrasound estimation of fetal size for suspected large-for-gestational-age unborn babies should not be undertaken in a low-risk population.

Routine Doppler ultrasound should not be used in low-risk pregnancies.

Fetal presentation should be assessed by abdominal palpation at 36 weeks or later, when presentation is likely to influence the plans for the birth. Routine assessment of presentation by abdominal palpation should not be offered before 36 weeks because it is not always accurate and may be uncomfortable.

Suspected fetal malpresentation should be confirmed by an ultrasound assessment.

Routine formal fetal-movement counting should not be offered.

Auscultation of the fetal heart may confirm that the fetus is alive but is unlikely to have any predictive value and routine listening is therefore not recommended. However, when requested by the mother, auscultation of the fetal heart may provide reassurance.

The evidence does not support the routine use of antenatal electronic fetal heart rate monitoring (cardiotocography) for fetal assessment in women with an uncomplicated pregnancy and therefore it should not be offered.

The evidence does not support the routine use of ultrasound scanning after 24 weeks of gestation and therefore it should not be offered.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Antenatal care quality standard

11. Fetal wellbeing – external cephalic version

9 Planning place of birth

See Antenatal care for uncomplicated pregnancies / Antenatal care for uncomplicated pregnancies: planning place of birth

10 Schedule of appointments

See Antenatal care for uncomplicated pregnancies / Antenatal care for uncomplicated pregnancies: schedule of appointments

11 Screening

See Antenatal care for uncomplicated pregnancies / Antenatal care for uncomplicated pregnancies: screening

12 Breech presentation at term

All women who have an uncomplicated singleton breech pregnancy at 36 weeks should be offered external cephalic version. Exceptions include women in labour and women with a uterine scar or abnormality, fetal compromise, ruptured membranes, vaginal bleeding and medical conditions.

Where it is not possible to schedule an appointment for external cephalic version at 37 weeks, it should be scheduled at 36 weeks.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Antenatal care quality standard

11. Fetal wellbeing – external cephalic version

13 Pregnancy after 41 weeks

Prior to formal induction of labour, women should be offered a vaginal examination for

membrane sweeping.

Women with uncomplicated pregnancies should be offered induction of labour beyond 41 weeks.

From 42 weeks, women who decline induction of labour should be offered increased antenatal monitoring consisting of at least twice-weekly cardiotocography and ultrasound estimation of maximum amniotic pool depth.

For information on methods of induction, and care of women being offered and having induction, see what NICE says on induction of labour.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Antenatal care quality standard

12. Fetal wellbeing – membrane sweeping for prolonged pregnancy

14 Models of care and staffing

Midwife- and GP-led models of care should be offered to women with an uncomplicated pregnancy. Routine involvement of obstetricians in the care of women with an uncomplicated pregnancy at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise.

See what NICE says on safe midwifery staffing for maternity settings.

15 See what NICE says on ensuring adults have the best experience of NHS services

See Patient experience in adult NHS services

16 Non-routine and complicated pregnancies

See what NICE says on intrapartum care for women with existing medical conditions,

intrapartum care for women with obstetric complications and pregnancy for information on non-routine and complicated pregnancies.

17 NICE Pathway on intrapartum care

See Intrapartum care

Types and frequencies of serious medical problems that can affect babies

Numbers and proportions of the individual components of the composite adverse outcomes measure recorded in the Birthplace UK (2011) study

Outcome	Actual number of babies affected out of [63,955 to 64,535]* (number per 1000)	Percentage of all adverse outcomes measured
Stillbirth after start of care in labour	14 out of 64,535 (0.22 per 1000)	5%
Death of the baby in the first week after birth	18 out of 64,292 (0.28 per 1000)	7%
Neonatal encephalopathy (disordered brain function caused by oxygen deprivation before or during birth) (clinical diagnosis)	102 out of 63,955 (1.6 per 1000)	40%
Meconium aspiration syndrome (the baby breathes meconium into their lungs)	86 out of 63,955 (1.3 per 1000)	34%
Brachial plexus injury	24 out of 63,955 (0.38 per 1000)	9%
Bone fractures	11 out of 63,955 (0.17 per 1000)	4%
TOTAL (of all outcomes included in the 'adverse outcome' composite measure)	255 out of 63,955 to 64,535) (approx. 4 per 1000)	99%**
Note: Each of the categories above are mutually exclusive and outcomes listed higher in the		

table take precedence over outcomes listed lower down. For example, if a baby with neonatal encephalopathy died within 7 days the outcome is classified as an early neonatal death.
* Denominator varies because of missing values.
** Does not equal 100% because of rounding.

Adverse outcome: in order to be able to count enough adverse events to be able to say that the results recorded are not just a result of chance, the Birthplace UK (2011) study used a composite definition of 'adverse outcome'. The definition includes the following outcomes: stillbirth during labour, death of the baby in the first week after birth, neonatal encephalopathy (disordered brain function caused by oxygen deprivation before or during birth), meconium aspiration syndrome, and physical birth injuries (brachial plexus injury and bone fractures). The term 'serious medical problems' has been used to describe this composite outcome in the recommendations.

Glossary

ECV

external cephalic version

MIDIRS

Midwives Information and Resource Service

RAADP

routine antenatal anti-D prophylaxis

RhD

rhesus D

Sources

Antenatal care for uncomplicated pregnancies (2008 updated 2018) NICE guideline CG62

Your responsibility

Guidelines

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.

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.

Technology appraisals

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

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so 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.

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.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance 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.