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