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