- 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 smoking: stopping in pregnancy and after childbirth. Also see the NICE guideline on smokeless tobacco: South

Asian communities.

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.

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:

- anti-D prophylaxis to rhesus-negative women in line with NICE's technology appraisal guidance on routine antenatal anti-D prophylaxis for women who are rhesus D negative (see also NICE's diagnostics guidance on high-throughput non-invasive prenatal testing for fetal RHD genotype)
- a blood test to check full blood count, blood group and antibodies.

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.