Intrapartum care for women with existing medical conditions or obstetric complications and their babies

Consultation on draft guideline - Stakeholder comments table

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Action on Smoking and Health	Guidance	General	General	Smoking is a major risk factor for adverse birth outcomes for both women and their babies but it is not identified in the guidance. Literature has demonstrated the negative impacts of smoking on maternal health. Compared to women who are not pregnant, pregnant women are at an increased risk of developing adverse events such as acute myocardial infarction, stroke, and venous thromboembolism.(1) Pregnant smokers have more than a 4-fold increased risk for acute myocardial infarction (95% CI 3.3, 6.4), 1.3-fold increased risk for deep vein thrombosis (95% CI 1.1, 1.6), and a 2-fold increased risk for pulmonary embolism (95% CI 2.1, 3.0).(1) Other effects of smoking during pregnancy include: Decreased fertility Ectopic pregnancies (implantation of a fertilised egg outside the uterus) Placental abruption (early separation on the placenta from the uterus) Placenta previa (placenta growing in the lowest part of the uterus) Preterm premature rupture of membranes Spontaneous abortion Stillbirth (2) Smoking during pregnancy has been linked with low birthweight in babies (babies being born less than 2500g).(3) Continuous smoking (smoking from conception to birth) has been shown to reduce birthweight by 162g among mothers who smoked 1-9 cigarettes per day, and up to 226g among mothers smoking more than 9	Thank you for this comment. The scope excluded "women in labour who are identified before or during labour to be at high risk of adverse outcomes solely because of personal or social circumstances" (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2). As acknowledged by you, there is existing NICE guidance on smoking in pregnancy. In addition to the guidelines cited by you there are also NICE guidelines on antenatal care for uncomplicated pregnancies (CG62) and pregnancy and complex social factors (CG110) which address smoking in pregnancy. Intrapartum care for women who smoke would not be different from that for women at low risk in the intrapartum period, although where the associated obstetric risks of smoking, such as low birthweight, fall within the scope of the guideline the baby is identified in labour to be at high risk of adverse outcomes and will be covered by this guideline

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				cigarettes per day, compared to mothers who don't smoke.(3) Low birthweight has been associated with neonatal and infant mortality. (4) Additionally, children born with low birthweight are more at risk of developing developmental delays (5), and intellectual impairment.(6) Low birthweight has also been linked to the development of morbidities later in life including obesity, type 2 diabetes, hypertension, coronary heart diseases and metabolic syndrome.(3) Other effects of smoking on the child include: Malformations Asthma Respiratory deficits SIDS (Sudden Infant Death Syndrome) Behavioural difficulties (2) Currently around 10.4% of women are smoking at delivery with a significant social and age gradient to smoking rates.(7)(8) Rates of smoking in white women in routine and manual occupations are currently more than double that of women on average. This inequality for all women is reflected in pregnant women (data analysis courtesy of Public Health England, Published in Challenge Group report)(8) Women under 20 at 6 times as likely to smoke and smoke during their pregnancy as those over 35, and are less likely to quit (9). Women who live with a smoker are 6 times more likely to smoke throughout pregnancy and those who live with a smoker and	

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				manage to quit are more likely to relapse to smoking once the baby is born (data analysis courtesy of Public Health England, Published in Challenge Group report)(8) The guidance should: Include a section on smoking as a risk factor – similar to the section on obesity – which includes smoking in the home by someone other than the mother, both pre and post-natal, as an increased risk factor for adverse outcomes including Sudden Infant Death Syndrome. Require health professionals to identify women who smoke at first contact and highlight smoking as a risk factor that should be taken into account when planning labour and defining care pathways. Link with existing NICE Guidance on smoking and pregnancy and smoking in secondary care.(10)(11) References: 1. Roelands J, Jamison MG, Lyerly AD, James AH. Consequences of smoking during pregnancy on maternal health. Journal of women's health (2002). 2009;18(6):867–72. 2. Rogers JM. Tobacco and pregnancy: Overview of exposures and effects. Vol. 84, Birth Defects Research Part C: Embryo Today: Reviews. Hoboken; 2008. p. 1–15. 3. Juárez SP, Merlo J. Revisiting the Effect of Maternal Smoking during Pregnancy on Offspring Birthweight: A Quasi-Experimental Sibling Analysis in Sweden. PLoS ONE. 2013;8(4). 4. Wilcox AJ, Russell IT. Birthweight and perinatal mortality: II. On weight-specific mortality. International journal of epidemiology. 1983;12(3):319.	

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				5. Hollomon HA, Scott KG. Influence of Birth Weight on Educational Outcomes at Age 9: The Miami Site of the Infant Health and Development Program. Vol. 19, Journal of Developmental and Behavioral Pediatrics. 1998. p. 404–10. 6. Tong S, Baghurst P, McMichael A. Birthweight and cognitive development during childhood. Journal of Paediatrics and Child Health. 2006;42(3):98–103. 7. NHS. Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 1, 2018-19. 8. Smoking in Pregnancy Challenge Group. Review of the Challenge 2018. 9. NHS. Infant Feeding Survey - UK, 2010 10. NICE. Smoking: stopping in pregnancy and after childbirth. Public health guideline [PH26]. June 2010. 11. NICE. Smoking: acute, maternity and mental health services. Public health guideline [PH48]. November 2013.	
Alliance Pharmaceuticals Ltd	Guideline	41	24	Where oxytocin is suggested alone as the preferred additional management for intrapartum bleed. We would like to draw the committee's attention to the new 2018 Cochrane systematic review on the management of PPH which is leading to changes in UK clinical practice: https://pregnancy.cochrane.org/news/featured-review-uterotonic-agents-preventing-postpartum-haemorrhage The authors of this Cochrane analysis, and peer reviewers, independently reviewed the data from over 140 studies, involving	Thank you for this comment. The Cochrane review cited by you focuses on the prevention of postpartum haemorrhage rather than the management of intrapartum haemorrhage therefore it cannot be included in this guideline. In addition, recommendation 1.14.7 states that "Management may also include: amniotomy or oxytocin" leaving the decision open to clinicians

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				88,947 women; they agreed that ergometrine plus oxytocin (Syntometrine), misoprostol plus oxytocin, and carbetocin were significantly more effective drugs for reducing excessive bleeding and demonstrated lower adverse events at childbirth when compared with oxytocin alone which has been traditionally used alone to manage this condition. Furthermore, Oxytocin was ranked fourth with close to 0% cumulative probability of being ranked in the top three for PPH ≥ 500 mL. The review also acknowledged that this was contrary to traditional management recommendations but this analysis provided "robust effectiveness and side-effect profiles for each drug". Alliance have also been made aware from representatives that many UK specialist departments are already changing local guidelines to reflect this new evidence which features as the highest possible level of GRADE criteria when assessing the totality of the clinical evidence base. It is important that NICE guidance is updated to reflect this important change in clinical management recommendations to benefit patient care by reducing adverse events, minimising harm, potentially enhancing patient recovery time and leads to an evidence based improvement in birth outcome.	
Alliance Pharmaceuticals Ltd	Guideline	58	17	Where oxytocin is cited as the, "uterotonic of first choice" See above	Thank you for this comment. We believe this refers to the rationale and impact section for the management of the third stage of labour for women with heart disease. We recommend that women with heart disease classified as

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					"modified WHO stage 3 and 4" should receive oxytocin as a first-line uterotonic. We made this recommendation based on the limited data available and our clinical knowledge. In women with heart disease, the clinician has to balance the risk of uterine haemorrhage with the risk of vasospasm aggravating severe heart disease. Under these circumstances, clinical decision making is difficult and invariably a compromise. We agreed to include a recommendation stating that an multidisciplinary team should be involved in determining the individual woman's exact care plan. In addition, our recommendation to use oxytocin is in line with the current European Society of Cardiology guidelines, which state "in women who are on antenatal anticoagulation, it should be considered to actively manage the third stage of labour with oxytocin". Finally, we are aware that many of the studies included within the Cochrane review to which you refer in the earlier comment excluded women with heart disease
Alliance Pharmaceuticals Ltd	Guideline	65	13-15	Where oxytocin advised as alone to reduce postpartum haemorrhage See above	Thank you for this comment. This comment on the rationale and impact section relates to recommendation 1.6.8 in the consultation draft guideline, which states "Offer active management rather than physiological management of the third stage of labour for women with bleeding disorders, in line with the NICE guideline on intrapartum care for healthy women and babies". It is not within the remit of this guideline to update recommendations relating to the NICE guideline on

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					intrapartum care for healthy women and babies (CG190), but the new evidence cited by you will be considered by the NICE surveillance team when reviewing whether the guideline on intrapartum care for healthy women and babies requires updating
Association of Anaesthetists	Guideline	24	25	Does "jugular venous pressure" mean Observation externally of the jugular venous pulsation or central venous pressure measurement via a jugular central venous catheter? It would be hard to support routine central venous catheter insertion for monitoring purposes alone. This statement needs clarifying. External assessment of jugular pressures is inaccurate, difficult and few practitioners these days have experience. Perhaps this point would better say "Consider insertion of central venous catheter for pressure monitoring' or similar? Equally chest auscultation in not routinely required every 4 hours. Perhaps better to suggest doing if concerns with respiratory rate or oxygen saturations?	Thank you for this comment. After consideration we have decided to take out jugular venous pressure from the list of observations. However, we have decided to keep the 4-hourly chest auscultation as ward rounds would normally happen every 4 hours and it was considered important to carry out chest auscultation as part of the regular observations
Association of Anaesthetists	Guideline	25	20	Same comment as above	Thank you for this comment. After consideration we have decided to take out jugular venous pressure from the list of observations. However, we have decided to keep the 4-hourly chest auscultation as ward rounds would normally happen every 4 hours and it was considered important to carry out chest auscultation as part of the regular observations
Association of Anaesthetists	Guideline	26	11	Same comment as above	Thank you for this comment. After consideration we have decided to take out jugular venous pressure from the list of observations. However, we have decided to keep the 4-hourly chest auscultation as ward rounds would normally

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					happen every 4 hours and it was considered important to carry out chest auscultation as part of the regular observations
Association of Anaesthetists	Guideline	36	25	The consultant Obstetric anaesthetist does not always need to be present. This will depend on the skill and seniority of the resident anaesthetist and on the proximity and other duties of the consultant. Saying they must be present is too restrictive. They should be consulted and must attend if the clinical picture requires it, but it is hard to justify making it mandatory for them to be present in all cases.	Thank you for this comment. We have discussed this and agreed that the consultant obstetric anaesthetist does not always need to be present and that stating they must be present is too restrictive and may delay appropriate care. Therefore, the recommendation has now been edited to state that for women in labour with sepsis and signs of organ dysfunction, regional anaesthesia should only be used with caution and advice from a consultant obstetric anaesthetist, and with a senior anaesthetist present
Association of Anaesthetists	Guideline	41	6	"Senior" here requires some clarification. Depending on the degree of bleeding, mandating this may be overkill. Could this section reflect the range of scenarios experienced in real life? It may be appropriate to consult with a senior, rather than mandating their attendance.	Thank you for this comment. The terms "senior" and "consultant" are both used in the guideline as they would be in clinical practice. "Senior" refers to a clinician with expertise in providing care in particular circumstances, whether they be a consultant or a senior registrar with specialist training in the relevant clinical area. Where there is a specific requirement to involve a consultant in the woman's or baby's care this is specified in the recommendations. The term "senior" typically refers to a clinician with at least 5 years' specialty training. Moreover, the recommendation cited in the comment refers to senior involvement, and not necessarily physical attendance
Association of	Guideline	47	6	Arguably, this is exactly the group of women who should have a cannula inserted routinely before a problem arises, particularly if they have known difficult venous access and/or their Obstetric	Thank you for this comment. As explained in the rationale and impact section, no evidence was found for intravenous cannulation for women in labour with a

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Anaesthetists				history suggests urgent venous access might reasonably be required. This is a higher risk group. It is a balance of risk vs benefit, but there is very little risk associated with cannula insertion, yet ready venous access can be metaphorically and literally life-saving and this should be reflected in these guidelines.	previous caesarean section. We agreed that the chance of needing intravenous access for urgent blood transfusion was unlikely to be higher in these women, and so recommended that cannulation should not be routine. We discussed this comment and agreed that we should take women's experiences into account and inserting an intravenous cannula may be unpleasant for women. This has now been noted in the committee's discussion of the evidence section in evidence review S. We have agreed to keep recommending to not routinely insert an intravenous cannula for women in labour who have had a previous caesarean section
British HIV Association (BHIVA)	Guideline	46	12to 14	The selection of suspected sexual abuse as especially high risk for HIV is unusual and very specific. Any sexual assault would, of course, be considered high risk as it is usually unprotected but, more importantly, an HIV test should be offered to any woman with an undocumented HIV-negative test presenting in the third trimester and we would recommend that this be included in the recommendation.	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis
British HIV Association (BHIVA)	Guideline	6	18-19	We would recommend that the multidisciplinary team has both an Obstetric and speciality physician familiar with the woman's existing medical condition – not one or the other. This works very well in the context of HIV where both the Obstetrician and HIV specialist work together to provide best care for the woman.	Thank you for this comment. We considered this and have made some revision to the wording which reflects that it may be appropriate to include an obstetrician and a specialty physician familiar with the woman's condition
British HIV Association (BHIVA)	Guideline	87	20	We would recommend the use of the terminology vertical transmission in place of mother-to-child transmission, which women living with HIV find is stigmatising.	Thank you for this comment. The wording has been changed as suggested

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British HIV Association (BHIVA)	Guideline	88	1to4	Although rapid HIV testing, i.e. point of care testing may not be available, some laboratories can turn around an HIV test within 60 minutes if the request is urgent and the laboratory is contacted in advance and presented with clinical details. We would recommend, therefore, that this be included in the guideline as an option.	Thank you for this comment. We have amended the text to reflect that rapid HIV testing may be available in some settings and not in others
British Intrapartum Care Society	Guideline	21	Table 2	In the table IPT should be ITP	Thank you for this comment. The typographical error has been corrected
British Intrapartum Care Society	Guideline	29	2to3	Some members have reported that they have recently purchased beds that have a weight limit of 227kg, has this weight limit recommendation with UK bed manufacturers?	Thank you for this comment. The safe working load limit of 250 kg is aligned with guidance from the Centre for Maternal & Child Enquiries (CMACE) and the Royal College of Obstetricians and Gynaecologists (RCOG) (https://www.rcog.org.uk/globalassets/documents/guidelines/cmacercogjointguidelinemanagementwomenobesitypregnancya.pdf). We have clarified this in the committee's discussion of the evidence section in evidence review I (see benefits and harms, p 36). However, the weight limit you are referring to might relate to the weight limit regarding patient capacity as opposed to the weight limit regarding safe working load. For example "TotalCare Bariatric Plus Bed" by the manufacturer Hill-Rom has a weight limit of 250 kg for safe working load and 227 kg for patient capacity (https://www.hill-rom.com/globalassets/website-documentation/english-websites-us--int/beds-us--int/totalcare-bariatric-plus---int/totalcare-bariatric-plus-bed-brochure-5en125301-02.pdf)

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British Intrapartum Care Society	Guideline	38-39	16-23	Please consider adding something around ascertaining allergies and documenting them on the drug chart	Thank you for this comment. We discussed the issue raised and agreed that the suggestions made by you cover accepted practice. The guideline is not intended to cover all aspects of care but aims to address areas where guidance is especially needed due to variation in practice, and so we agreed not to add this suggestion to the recommendations
British Intrapartum Care Society	Guideline	45	15-25	Please consider adding undocumented migrants to the list	Thank you for this comment. The suggested change has been made
British Intrapartum Care Society	Guideline	General	General	Our members have voiced some concerns about the recommendation for 4 hourly JVP measurements in a wide variety of clinical scenarios. This is not a skill midwives generally have, and may not be realistically be possible on a busy labour ward to be done as per the recommendations by the medical members of the team.	Thank you for this comment. After consideration we have decided to remove jugular venous pressure from the list of observations
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	12 to 13	9 to 25	Insert comment about starting treatment in the intrapartum period and outline recommendations for treatment choices	Thank you for this comment. Due to the heterogeneous nature of heart failure and its treatment it would not be possible to describe all potential treatment options in this guideline. The recommendations state that the advice of a cardiologist should be sought once heart disease is identified to ensure that the woman has the relevant expertise needed to treat her condition
Chelsea & Westminster Hospital NHS	Guideline	16	Table 1	Include dose and route of administration for oxytocin [im? iv infusion??] and misoprostol [PV, PO, wide range of doses…]	Thank you for this comment. We agree that this is an important point; however, there are many different options for mode of delivery of therapy and to specify the mode of delivery precisely is not possible. The table is a simple

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Foundation Trust					guide to help clinicians make decisions, but cannot be used as a calculator of exact dosages
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	17	19-20	Specify name of commonly used PG F2a i.e. Carboprost.	Thank you for this comment. We have added carboprost to the recommendation as an example of prostaglandin F2 alpha
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	17	19-20	Consider adding something like 'except following MDT discussion concerning relative risks of severe on-going haemorrhage from uterine atony'	Thank you for this comment. We do not think that prostaglandin F2 alpha is ever appropriate for women with asthma and postpartum haemorrhage should be managed without delay, rather than waiting for a multidisciplinary team to convene
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	19	20	Annotate to explain that likelihood of bleeding in the baby is very low	Thank you for this comment. Whilst we recognise that the risk of bleeding is low we also note that the risk is unpredictable and therefore it is important to plan for bleeding in the baby
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	19-22	General	No mention of management of women who are haemophilia carriers or of their babies who may be [known to be] affected	Thank you for this comment. This guideline looked at different bleeding disorders but found very little evidence. It therefore focused on more prevalent conditions such as low platelet count. Very few women are haemophilia carriers

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Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	20	18	Add 'bear in mind that a difficult 2nd stage Caesarean may be more traumatic for the mother and/or baby than continuing with vaginal birth'	Thank you for this comment. We decided not to adopt your suggestion as a reference to the second stage of labour would imply that the woman was continuing with a vaginal birth
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	21	Table 2	Abbreviation IPT is used for immune thrombocytopenia - is this a typo for ITP?	Thank you for this comment. The typographical error has been corrected
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	21	Table 2	There is no information for maternal wellbeing about what to do if plat <50 except not to use epidural. Add more into this table or in section 1.6.6 'for women with suspected or actual ITP, and a count <50 take the following precautions to minimise maternal bleeding' to follow on from 1.6.5 which is about how to minimise risks of bleeding in baby [again annotate to indicate risk low]	Thank you for this comment. We made the recommendation to avoid regional anaesthesia and analgesia in women with a platelet count below 50 × 10^9/litre because we considered that it was an important matter for maternal safety given the risk of bleeding. We did not feel that we needed to spell out the alternatives, such as general anaesthesia, when regional anaesthesia is not offered
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	24	3	Add 'and if so consider a MRI spine during pregnancy to establish if other AVM are present or not'	Thank you for this comment. As you note, this issue affects a small group of people and usually the genetic burden would already be known, therefore, MRI would have already been taken earlier or at least during the antenatal period. MRI in the intrapartum period would not be feasible. However, to make sure that we cover people with unknown genetic history, we have amended the

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					wording of the recommendation to include women with unknown genetic history
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	24	4	Offer link to definition of chronic kidney disease stages 1-5	Thank you for this comment. We have added chronic kidney disease stages to the "Terms used in this guideline" section where we have inserted a link to the NICE guideline on chronic kidney disease (CG182)
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	28	14-18	1.9.4 and 1.9.5 should be merged / clarified - they seem to overlap and contradict each other	Thank you for this comment. We agree that the recommendations were unclear, although they refer to two different populations: the first refers to women with a BMI over 30 with reduced mobility and the next one refers to women with BMI over 30 with adequate mobility. We have amended the wording to make this clear
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	28	3	Assume this is intrapartum fetal monitoring – clarify please	Thank you for this comment. We have clarified in the recommendation that this refers to fetal monitoring during the intrapartum period
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	29	13-15	Add a comment about what constitutes suitable equipment and expertise	Thank you for this comment. Please see evidence review I for further discussion of the recommendations, for example, "The committee emphasised that the list was not exhaustive, and they intended to focus the considerations of healthcare professionals on whether the equipment at hand was adequate for the degree of obesity in an individual woman. The committee also emphasised that

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					the items in the list were not presented in order of priority; all centres that care for very obese women should consider the availability and suitability of each item of equipment used in the intrapartum period"
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	29	7to12	Add armchair and wheelchair of appropriate size and strength to the list of equipment required	Thank you for this comment. The list of equipment in the recommendation is not exhaustive and other equipment might equally be needed. We have added wheelchairs to the list as suggested
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	30	25	Add 'preterm labour before 37weeks' or 'multiple pregnancy'	Thank you for this comment. The list refers to the complications covered by the guideline. Multiple pregnancy is not covered by this guideline as there is an existing NICE guideline on this topic (CG129). Preterm labour is only covered by this guideline if it is in the presence of relevant complications, otherwise please refer to the NICE guideline on preterm labour and birth (NG25)
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	7	22	Add link to NYHA definitions, or include it directly	Thank you for this comment. We have added the reference: https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure
Chelsea & Westminster Hospital NHS	Guideline	8	5	Add comment about importance of reliable contraception and pre-pregnancy planning in women with mechanical valves, and pre-pregnancy discussion of options and risks	Thank you for this comment. Contraception is out of scope for this guideline, hence it is not covered here. We refer you to recommendation 1.1.3, which is related to

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Foundation Trust					information on intrapartum care for women with existing medical conditions before conception
Chelsea & Westminster Hospital NHS Foundation Trust	Guideline	8	5	Expand 'when pregnancy is confirmed' to state 'when pregnancy is confirmed as an on-going intrauterine pregnancy'	Thank you for this comment. The suggested terminology is too specific and does not add anything to the meaning of the recommendation. Recommendations need to be easily understood by both healthcare professionals and the women who the guideline is targeted towards
Clinical Innovations	Guideline	21	10	Management of the third stage of labour for women with bleeding disorders 1.6.9: Consider placing a prophylactic balloon tamponade device given these patients' propensity for postpartum haemorrhage	Thank you for this comment. We are unable to make the suggested change as we did not look for evidence for a prophylactic balloon tamponade. We considered that the use of oxytocin administered by intramuscular injection in the management of the third stage of labour was associated with risks for women with bleeding disorders and this was the focus of recommendation 1.6.9. The recommendation has been reworded to clarify that intramuscular injections should be avoided
Clinical Innovations	Guideline	22	2	Postpartum management for women with bleeding disorders 1.6.10: Replace "estimate blood loss" to "quantify blood loss"	Thank you for this comment. We have changed the bullet to read "measurement of blood loss"
Clinical Innovations	Guideline	23	19-22	Care for women with cerebrovascular malformation at high risk of intracranial bleeding 1.7.7: avoid ventouse	Thank you for this comment. Babies of women with cerebrovascular malformation at high risk of bleeding are not themselves at a higher risk of bleeding, therefore, avoiding ventouse is not an issue here unlike with babies of women with certain bleeding disorders (see recommendations on women with bleeding disorders)

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Group B Strep Support	Guideline	34	1.2	It would be useful to include a recommendation for using intravenous antibiotics in labour in the presence of maternal pyrexia, as described in the RCOG's 2017 update to their Greentop guideline on group B Strep Recommendation 7.2 (How should labour in a woman with a temperature of 38°C or greater and without known GBS colonisation be managed?) https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14821	Thank you for this comment. Colonisation of women in pregnancy by group B streptococcus was explicitly excluded from this guideline because of the RCOG Green-top Guideline cited by you. This is noted in the guideline scope (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2)
Group B Strep Support	Guideline	General	General	We are disappointed that women who are known to carry GBS during the current pregnancy, or who have previously carried GBS or had a baby with GBS infection, are excluded from this guideline.	Thank you for this comment. GBS was excluded from the scope because prevention and management of infection in the baby is covered in the NICE guideline on neonatal infection (CG149) and the NICE-accredited RCOG guideline on the prevention of early-onset neonatal group B streptococcal disease (Green-top Guideline 36)
Intensive Care Society	Comment form	Question 1	Question 1	Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why? Promotion of better recognition and management of deterioration by team work between intensive care and critical care outreach with maternity services as described in the intercollegiate document 'Care of the Critically Ill woman in childbirth; enhanced maternal care'. Key messages Working in teams Women who become acutely unwell during pregnancy, labour and the postnatal period should have immediate access to critical care, of the same standard as other sick patients, irrespective of location. There are different models to deliver this care. These depend upon	Thank you for this comment which will be considered by NICE where relevant support activity is being planned

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				adequate numbers of staff being available with the knowledge and skills to detect deterioration, escalate care, and deliver appropriate care to a woman who becomes critically ill in any setting. We have attempted to define this knowledge and skill set as enhanced maternal care (EMC). Our aim is to promote the development of these competencies and encourage closer working between maternity and critical care teams to optimise care for critically ill women, irrespective of where it is delivered. Enhanced maternal care EMC is driven by a set of competencies required to care for women with medical, surgical or Obstetric problems during pregnancy – peri- and post-partum – but without the severity of illness that requires admission to a critical care unit. This care can be provided by any practitioner with the necessary skills. Education and training Education and training in the care of women who are acutely deteriorating/critically ill is essential for all teams involved in maternity care. This includes Obstetricians, midwives, Obstetric anaesthetists, physicians, intensivists, and critical care nurses. This can be achieved using existing teaching, training and organisational resources, as well as appropriate changes to the existing curricula. It will require collaboration between critical care and maternity services within local settings, as well as regional networks. An early warning system modified for Obstetrics An early warning system modified for Obstetrics is fundamental and should be used for all women presenting to acute care services who are pregnant, or who are within 42 days of delivery. We recommend	

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				key components for an Obstetric early warning system, with the aim of developing a national Obstetric early warning system. Where care is delivered It is anticipated that the large majority of acutely unwell maternity patients can have care safely provided by appropriately trained staff on the maternity unit. Transfer to a critical care unit may be required occasionally if the patient's condition warrants that level of care. This model will generally allow the woman and her baby to be together if care is required in the postpartum period, and will facilitate step-down care when, as is often the case, the woman's condition improves. In some cases, the skill mix on the maternity unit can be enhanced, if needed, by the critical care outreach team. Care of the acutely ill woman in the general critical care unit Critical care units should have a named lead for maternal critical care to act as the liaison between critical care and Obstetric services. Shared care principles (i.e. effective, consultant-led teamwork) are essential to deliver appropriate Obstetric and critical care. The Obstetric team (usually consisting of a consultant Obstetrician, consultant Obstetric anaesthetist and a midwife) should review any Obstetric patients admitted to the general critical care unit at least once every 24 hours. All units should have established follow-up/rehabilitation services as recommended by the National Institute for Health and Care Excellence (NICE) and in the Guidelines for the provision of intensive care services, 2015. Midwives should be involved in follow-up where there are ongoing issues due to the birth.	

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Intensive Care Society	Comment form	Question 2	Question 2	Would implementation of any of the draft recommendations have significant cost implications? Yes- for staff education but obvious significant savings in the longer term and reduced morbidity of sepsis campaign.	Thank you for this comment which will be considered by NICE where relevant support activity is being planned
Intensive Care Society	Comment form	Question 3	Question 3	What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Good team work within hospitals using existing resources. Better networking.	Thank you for this comment which will be considered by NICE where relevant support activity is being planned
Intensive Care Society	Document as a whole	General		Morbidity is rising in the UK and developing world owing to more mothers who have co-existing medical illnesses, obesity and increasing age at pregnancy. The numbers of women suffering from "indirect" causes of maternal death (i.e. not diseases associated only with pregnancy such as preeclampsia) has not changed in recent years despite many efforts to address this. Much focus is placed on the early recognition of critical illness such a sepsis using early warning scores, escalation pathways and associated education for midwives and Obstetricians. Intensivists and critical care and outreach specialists have pioneered substantial changes at a national level in early recognition and management of critical illness (NEWS1&2 scores) Rapid response systems of care exist in majority of hospitals (where critical care outreach are linked directly to the ward patients and will be alerted o a deterioration in early warning score, often via electronic data collection). In the main, the Obstetric population do not have access to these important and	Thank you for this comment. The two guideline committees both included an intensive care unit consultant (i.e. one for the medical stream and one for the obstetric stream) and therefore we consider that critical care expertise was sufficiently represented on the guideline committee. The proposed committee composition was discussed at a stakeholder workshop and stakeholders did not suggest that additional critical care expertise would be required. Committee members were appointed after open application and interview in line with the usual procedures followed by NICE and not nominated by learned societies. With respect to incorporating the MCC guidelines: 1. NICE guidelines are developed according to a specific methodology as outlined in the NICE guidelines

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				effective facilities and education resources and this "silo" mentality needs to be rectified. This is compounded by midwifery and Obstetrician staff shortages and a lack of training in this area. A closer partnership between Obstetrics/midwifery and intensive care and critical care outreach is essential. The new intercollegiate guidance document Care of the Critically ill Woman in Childbirth; Enhanced Maternal Care underlines and recommends this partnership. https://www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/enhanced-maternal-care-guidelines-2018 It has been an oversight to have omitted to formally invite a member of a critical care faculty or specialist society onto the GDG and incorporate the intercollegiate MCC guidelines that were published last July (two years consultation). Members of your IPCHR GDC were also present on the intercollegiate MCC guidelines group so this is surprising and unfortunate. The MCC guidelines place emphasis on the importance good teamwork and collaboration between maternity and critical care and early recognition of critical illness and early warning systems incorporating critical care outreach nurses and intensivists. The key messages are very relevant and should be included in the IPC HR. This is an Obstetric patient safety issue; these patients are not receiving the same standards of care as non Obstetric patients in hospital. A separate section to include in the final NICE IPCHR guideline	manual (https://www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf). NICE does not incorporate the guidelines of external bodies as they are not developed using NICE methods. 2. The MCC guideline was published only recently (July/August 2018), and appeared too late for consideration as 'expert opinion' during the guideline development. 3. There is a considerable emphasis on multidisciplinary working throughout the NICE guideline which is entirely consistent with the MCC guideline. 4. Early warning systems, staff training and resources were not included in the scope of the NICE guideline

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				could be a way round this omission.	
Midwifery Unit Network	Evidence review L	25	25	Benefits and harms. MUNet notes and applauds the evidentially correct phrase 'continuous cardiotocography (electronic fetal monitoring) is used as a step up from intermittent auscultation', there being no evidence (as shown in CG190) that CTG is actually superior to or more useful than IA in any population, save in relation to neonatal seizures, as discussed in the relevant Cochrane review and CG190.	Thank you for this comment (which relates to evidence review I, not evidence review L as stated by you). We have amended this section as the wording incorrectly implied there to be clinical evidence; please see the benefits and harms section in the committee's discussion of the evidence). Whilst we acknowledge the lack of evidence, we are primarily concerned with achieving effective monitoring of the fetal heart and from our experience having a low threshold for using continuous cardiotocography is needed as auscultating the fetal heart is often difficult in this population
Midwifery Unit Network	Evidence review L	25	29-42	MUNet is unclear what published research evidence there is that EFM is proven to result in 'better identification of fetal heart rate abnormalities' in this or any other population – if there is no evidence, the Committee should not make any assertion implying that there is.	Thank you for this comment (which relates to evidence review I, not evidence review L as stated by you). We have amended this section as the wording incorrectly implied there to be clinical evidence; please see the benefits and harms section in the committee's discussion of the evidence). Whilst we acknowledge the lack of evidence, we are primarily concerned with achieving effective monitoring of the fetal heart and from our experience having a low threshold for using continuous cardiotocography is needed as auscultating the fetal heart is often difficult in this population
Midwifery Unit Network	Evidence review L	25	35-36	MUNet queries whether the known increase (compared to IA) in operative and surgical birth with electronic fetal monitoring is ever a 'minor' matter, with reference to paper 2 of the Lancet series on caesarean birth just published, for example (a review on short-term	Thank you for this comment (which relates to evidence review I, not evidence review L as stated by you). We have amended this section as the wording was indeed incorrect and have added the suggested edit; please see

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				and long-terms effects of caesarean birth). When making trade offs of risks and benefits, as women, supported by their care givers, often have to do, rating the benefits of a course of action (e.g. a better chance of hearing the fetal heart accurately with CTG than with IA when the woman is obese – but is this presumed, or proven? – and so being able to screen for signs of fetal distress) more highly than the risks associated with it (e.g. false positive readings, leading to an unnecessary caesarean birth) does not render the risk-outcome 'minor' – merely differently rated, in this particular decision, because of the particular circumstances. We suggest 'The harms of using continuous monitoring are likely to be acceptable to the woman in comparison to its benefits in detecting fetal heart rate abnormalities where intermittent auscultation is difficult to achieve because of the woman's BMI.'	the benefits and harms section in the committee's discussion of the evidence in evidence review I. We agree that continuous cardiotocography is not without harms, and the benefits and harms of the alternative approaches should be discussed and weighted with the woman and the decision should depend on the preference of the woman. Ultimately the fetal heart must be monitored by the means that is most effective and sometimes this means using continuous cardiotocography
Midwifery Unit Network	Evidence review L	25	43-47	MUNet notes that many clinicians and many women wrongly believe that electronic fetal monitoring is diagnostic, and that it improves fetal outcomes compared to IA significantly, despite the lack of evidence for this. Given that any reduced anxiety in the woman if she chooses EFM is likely to be attributable to believing that it is diagnostic and effective, it is disappointing that the Committee did not discuss the importance of unbiased, evidence-based information-giving and discussion, at this point (and not just at lines 4-5 on p26)	Thank you for this comment. We have amended this section as we want to emphasise the importance of providing information to the woman to support her in her decision making. We have also edited the text to emphasise that the evidence base is not clear on this, therefore, the decision should be based on the woman's preference. Please see the benefits and harms section in the committee's discussion of the evidence in evidence review I
Midwifery Unit Network	Evidence review L	26	18-21	MUNet is disappointed that the Committee did not incorporate any reference in its discussions and this review to the NPEU study on the impact of maternal obesity on intrapartum outcomes in 'otherwise low risk women': a secondary analysis of the Birthplace	Thank you for this comment. Place of birth was outside the scope of this guideline. The scope of the section on obesity focused on specific review questions: assessing fetal presentation in early labour; fetal monitoring during

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				national prospective cohort study. https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/1471-0528.12437 MUNet is concerned that the recommendations on care of obese women will have an unfortunate impact on individualised care planning, as together they imply that women with a raised BMI can only be cared for safely in an Obstetric unit, yet evidence is emerging that this is not always the case (see paper above). MUNet is aware that a UKMidSS study (Study 1 Severe obesity) will be published soon and urges NICE to contact NPEU/UkmidSS to discuss making findings available to NICE and the Committee ahead of publication to inform these recommendations.	labour; use of ultrasound for assessing needle siting for central neuraxial blockade; optimal position in the second stage of labour; and additional equipment needed to ensure optimal care. The Birthplace national prospective cohort study publication (Hollowell 2013) is not relevant for these questions. Upcoming publications will be considered when NICE conducts regular surveillance reviews to assess whether the guideline needs updating. The recommendations do not state that women with a BMI over 30 need to be cared for in an obstetric unit, and they specifically encourage individualised care planning and risk assessment. The recommendations also aim to ensure that where special measures, such as size-appropriate equipment, is needed this would be available to the woman
Midwifery Unit Network	General	General	General	Midwifery Unit Network (MUNet) is based at City University, London, and networks midwifery units and their staff across the UK and Europe, providing networking forums, advice training and opportunities to meet at conferences and events. MUNet aims to promote and support the implementation, development and growth of midwifery units across Europe. We want midwifery units to become the main care pathway for healthy women at low risk of complications with straightforward pregnancies. MUNet recently published Midwifery Units Standards (accredited by the European Midwives Association).	Thank you for this comment. We have re-examined the wording of recommendations in the light of specific comments received about language and made a number of revisions in order to give greater recognition to the woman as an informed decision-maker regarding her care. Please refer to responses to specific comments for further details of the amendments made. Place of birth is not covered in the guideline scope (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2). This was because

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				As a registered stakeholder, MUNet has accepted, and included in our response to this consultation, comments from our MUNet Advisory Group that reflect their broad knowledge of maternity care as midwives and doctors, service user advocates and academics. Before giving our detailed comments, MUNet makes the following general Observations on the draft Guideline: The language of the guideline could be a great deal more woman-centred – you will see that this is a recurring theme in our comments. Language reflects thinking – we urge the Committee to respond to and reflect the current focus on human rights in childbirth and culture in maternity services, and the fact that this guideline is for women as well as for those who care for them. Disappointingly, the draft recommendations do not clearly reflect the recommendations of NICE CG138 on information-giving – how to give information in an unbiased way needs to be shown explicitly, to change current custom and practice, and to support good practice (CG138 recommendation 1.5.24) The lack of a 'planning place of birth' section, to mirror and link with section 1.1 CG190, is disappointing – we understand that if this was not included at scoping it cannot now be added, but it is a curious omission, particularly as the admission criteria for midwifery units are changing over time, to be more inclusive (see UKMidSS for related research) The new guideline format that encourages readers to 'click through' from recommendations to rationale, to evidence, is an improvement on the format in which CG190 was published – it would still be helpful to have some kind of explicit flag about evidence status as	the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. The wording of recommendations to indicate the strength of the evidence is standard across all NICE guidelines and is explained in developing NICE guidelines: the manual (https://www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf)

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				many readers will not be familiar with the NICE 'code' that uses the 'strength' of the active verb (offer, consider etc) to flag this. In practice, this causes much confusion about what is 'evidence-based' and what is 'expert opinion-based'. NICE guidance is widely believed to be based on 'expert opinion about the evidence the experts are familiar with' rather than on systematic reviews identifying the best available evidence: countering this misapprehension is important if NICE guidance is to have the impact that it should. MUNet thanks the Committee and NICE team for their hard work and looks forward to seeing the final, published form of the Guideline.	
Midwifery Unit Network	Guideline		14-15	1.9.4 MUNet is puzzled by this suggestion that a position should be prescribed for the second stage of labour (or at all). What is the evidence supporting this if any? (If the discussion in the evidence review is referring to the BUMPES trial relating to position with epidural analgesia, please say so, and note also that a range of commentators regard this as having compared left lateral supine position with a seated – not actually upright - position.) How does it fit with supporting the woman's autonomy and her decisions, upright positions where possible, and the exercise of professional judgment by midwives when providing suggestions during a diagnosed delay in the labour/birth, when this is appropriate? The proposed recommendation is contrary to the philosophy of midwifery unit care, which sees the woman as the autonomous centre of the birth care. The recommendation unfortunately reads as though she is a risk	Thank you for this comment. This recommendation is for women with a BMI over 30 at the booking appointment and reduced mobility during the third trimester. Unfortunately the consultation version of the document had an omission of "with reduced mobility". We have now corrected this wording. There was no clinical evidence identified and the recommendation was based on the committee's experience. The committee balanced the benefits and risks of finding a comfortable position for the woman with reduced mobility in the second stage of labour to the benefits and risks of adequate access for healthcare professionals in case of a high-risk but low-probability emergency. In the committee's discussion of the evidence section in evidence review I we write:

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				and an object to be positioned and 'managed' rather than a competent adult being cared for. MUNet suggests that, in the absence of evidence, the Committee should refrain from making a recommendation that might be read as seeking to limit the appropriate exercise of professional judgement. If a recommendation is made, then please detail the discussion with the woman that will be necessary, with reference to review L page 30 lines 32-45, page 31 lines 1-15: it is the woman who makes a decision on what position she will adopt, once fully informed about the trade-offs involved.	"Based on their experience, the committee discussed how a left-lateral position was sometimes helpful for women with reduced mobility. They discussed how this position was usually comfortable for the woman, but at the same time allowed healthcare professionals to have access to the woman, for example, to provide peritoneal support. The committee agreed that in the event of an obstetric emergency such access would be potentially life-saving, but the left-lateral position was not the only position which would allow access in this way; however, it was likely that healthcare professionals (and especially midwives) would be most familiar with the position. Based on their experience, the committee determined that management only needed to change from recommendations in the NICE guideline on intrapartum care for healthy women and babies (CG190) if the woman's mobility was affected by her obesity. Consequently the committee determined that in women with a BMI over 30 kg/m^2 and adequate mobility there was no reason to manage labour and birth differently from the recommendations in the existing guideline." The previous recommendation outlines that assessment of the woman's mobility and birth plan should be done together with the woman during the third trimester. In practice this discussion will probably continue during labour but we found it important that these considerations are discussed with the woman before labour and birth. The position in which the woman chooses to give birth ultimately depends on the woman's

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					preference but we think that it is important that these considerations are discussed with the woman
Midwifery Unit Network	Guideline	10	20	1.3.17 MUNet supports a human rights focused approach to shared decision making in pregnancy, labour and birth. We therefore suggest that this recommendation needs to refer to the woman's opportunity to contribute to the emergency birth plan, so '1.3.17 For women with heart disease who have planned a caesarean section, develop an individualised emergency care plan with the woman in case they present in early labour, with new symptoms or with Obstetric complications.'	Thank you for this comment. The recommendation has been reworded to ensure it is clear that the woman is involved in developing her emergency birth plan
Midwifery Unit Network	Guideline	10	22-23	1.3.18 MUNet notes that this recommendation about pregnancy logically should be placed before the related recommendations about birth.	Thank you for this comment. The recommendations in this section have been re-ordered and re-structured in what we agree is a woman-centred perspective
Midwifery Unit Network	Guideline	10	4	1.3.14 MUNet supports a human rights focused approach to shared decision making in pregnancy, labour and birth. While appreciating that the recommended 'offer' is the start of a discussion between the woman and those caring for her, MUNet's view is that it is helpful to state that the woman is involved: it needs to be spelled out to promote good practice, so '1.3.14 Develop an individualised birth plan with the woman with heart disease covering all three stages of labour following multidisciplinary discussion involving the woman (outlined [etc - continue as drafted]'	Thank you for this comment. The recommendation has been amended to ensure it is clear that the woman is involved in developing her care plan
Midwifery Unit Network	Guideline	14	6	1.3.32 MUNet suggests 'involving a multidisciplinary team (outlines in recommendation 1.2.1) and the woman [etc]'	Thank you for this comment. We have amended the recommendation to include the term "and the woman" to ensure it is clear that the woman is involved in developing her care plan

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Midwifery Unit Network	Guideline	15	10	1.3.40 MUNet suggests 'involving a multidisciplinary team…and the woman'	Thank you for this comment. We have amended the recommendation to include the term "and the woman" to ensure it is clear that the woman is involved in developing her care plan
Midwifery Unit Network	Guideline	17	10	1.4.1 'epidural, and' (the woman will have only one epidural)	Thank you for this comment. We have corrected this to the single form "epidural"
Midwifery Unit Network	Guideline	17	13-15	1.4.2 MUNet is unclear (while noting the review question) why mechanical means of induction, e.g. Foley catheter, are not mentioned in the Committee's discussion, or indeed the recommendation. It is possible to make an individual care plan safely. See the relevant Cochrane review. This might include a woman with asthma that is well-controlled, and where induction is for a reason such as avoiding going over 41 weeks or 'social reasons' (i.e. not a more substantive medical reason), going on after induction by mechanical means to begin labour, or labour entirely, at home or in a midwifery unit, depending on an individualised assessment of risk factors, discussed with her, and the woman's preference https://www.cochrane.org/CD001233/PREG_mechanical-methods-for-induction-of-labour If there are relevant possibilities that are outside the scope of the review question, the recommendation needs to allude to them – otherwise, in practice, it may be interpreted as ruling out the other possibilities (i.e. mechanical means of induction)	Thank you for this comment. The scope of this review question was specifically on the safety of prostaglandins for induction of labour in women with asthma and did not cover induction of labour in women with asthma as such. Therefore, the referenced Cochrane systematic review is out of scope for this question as it is about mechanical methods of induction of labour and among women in general and not among women with asthma. The recommendations do not exclude other methods of induction of labour for women with asthma as there is no concern about the safety of them for women with asthma. We have added some discussion about this in the section on the committee's discussion of the evidence in evidence review D

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Midwifery Unit Network	Guideline	17	4 onwards	1.4 MUNet notes that many women who have mild or well controlled asthma and have no other complications will often have a straightforward pregnancy and birth – it would be helpful to see the recommendation saying that they should be reassured and treated as normal, including offering all places of birth (see CG190). An individualised plan of care should be drawn up about what asthma symptoms would be of concern and should prompt review during pregnancy, labour or the puerperium.	Thank you for this comment. Place of birth was outside the scope of this guideline as it is covered in the NICE guideline on intrapartum care for healthy women and babies (CG190). The scope of this section on women with asthma was limited to specific topics: the risks and benefits of different analgesia, and the safety of prostaglandins and other uterotonics in women with asthma. In the section 'Information for women with existing medical conditions' we recommend that women should be offered information about how their medical condition (asthma in this case) may affect their care during the intrapartum period and how labour and birth may affect their medical condition. As you state, many women with asthma will have a straightforward pregnancy and intrapartum period, however, we also recommend that an individualised intrapartum care plan should be prepared during pregnancy together with the multidisciplinary team. In this case it would include consideration for changes in asthma symptoms and a review of the care plan in such circumstances
Midwifery Unit Network	Guideline	18	3, 10	1.5.1 MUNet suggests this should read 'For women planning a vaginal birth'…'rather than 'For women having a vaginal birth and at 1.5.2 it is not clear whether this means planned or unplanned caesarean birth, or both	Thank you for this comment. We have amended the wording of the recommendations as suggested to "For women planning a vaginal birth..." and "For women having a planned or emergency caesarean section…" to clarify that the recommendation applies to both scenarios

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Midwifery Unit Network	Guideline	19	20	1.6.3 MUNet considers 'assume the baby will be at risk of bleeding' to be very negative language (women and doctors might think this is highly probable, although the risk is small) – we suggest 'plan as if the baby will be at risk etc…'	Thank you for this comment. We have made the change suggested to the wording of the recommendation
Midwifery Unit Network	Guideline	21	2	Table 2 – MUNet welcomes inclusion of the 'greater than 80' platelet count threshold as this often causes confusion in relation to Midwifery Unit bookings, and women with counts of less than or equal to 130 are often excluded from admission criteria	Thank you for this comment in support of the guideline
Midwifery Unit Network	Guideline	21	7to9	1.6.8 MUNet agrees 'offer active management' is reasonable in the case of bleeding disorders. We understand that there is a review in progress considering whether there is a net increase in secondary post-partum haemorrhage with active management compared to physiological management. We trust that publication of this will be picked up by NICE surveillance in due course, as the findings will be relevant to both this guideline and NICE CG190.	Thank you for this comment. We will make NICE aware of the forthcoming publication mentioned in case it is relevant for the next surveillance review for the NICE guideline on intrapartum care for healthy women and babies (CG190)
Midwifery Unit Network	Guideline	23	17-22	1.7.6 and 1.7.7 MUNet suggests reference to a plan for premature labour in 1.7.6 and that it should follow the 'planned vaginal birth recommendation'- which itself (current 1.7.7 could usefully refer to 'women who plan a vaginal birth', reflecting both her decision and the uncertainty about eventual mode of birth.	Thank you for this comment. We do not think the approach should differ for women in preterm labour as the risk of intracranial bleeding would be similar to those in term labour, therefore, we recommend that caesarean section be considered for women with a high risk of intracranial bleeding, after a full discussion with the woman of the benefits and risks. We have emphasised the importance of intrapartum care planning together with the woman and the specialist with expertise in managing neurovascular conditions in pregnant women in an earlier recommendation. We have also amended the wording to

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					say women "who prefer to aim for a vaginal birth" to account for the uncertainty of the actual mode of birth
Midwifery Unit Network	Guideline	23	2	1.7.3 MUNet supports the movement in maternity generally to make women fully aware that consent in pregnancy, labour and birth is theirs to give or decline to give, recognising that in society generally this is not always well-understood. We therefore suggest 'and base the recommendation to the woman on Obstetric indications, taking into account the woman's preference. Support the decision she makes.' (recognising the roles of both the woman and the doctor in this dialogue).	Thank you for this comment. We have amended the wording to reflect that the woman's preference should be the basis for the discussion and shared decision making. We decided not to add "support the decision she makes" as this should be standard practice and it is outlined in the NICE guideline on patient experience in adult NHS services (CG138) (see recommendation 1.3.8 in CG138 "Respect and support the patient in their choice of treatment, or if they decide to decline treatment") which we have added a reference to earlier in the guideline in relation to information sharing and shared decision making
Midwifery Unit Network	Guideline	26	17	1.8.11 MUNet suggests 'managing renal conditions in pregnant women and the woman as early as possible in the antenatal period'	Thank you for this comment. We have amended the wording of the recommendation to emphasise that the woman should be included in her intrapartum care planning
Midwifery Unit Network	Guideline	26	22-23	1.8.12 MUNet suggests 'and base the recommendation to the woman on Obstetric indications, taking into account the woman's preference. Support the decision she makes' (recognising the roles of both the woman and the doctor in this dialogue).	Thank you for this comment. We have amended the wording to "…discuss timing and mode of birth with the woman and her birth companion(s) based on the woman's preference and obstetric indications" to reflect that the woman's preference should be the basis for the discussion and shared decision making. We decided not to add "support the decision she makes" as this should be standard practice and it is outlined in the NICE guideline on patient experience in adult NHS services (CG138) (see

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					recommendation 1.3.8 in CG138 "Respect and support the patient in their choice of treatment, or if they decide to decline treatment") which we have added a reference to earlier in the guideline in relation to information sharing and shared decision making
Midwifery Unit Network	Guideline	27	14-15	1.8.16 MUNet suggests 'and base the recommendation to the woman on Obstetric indications, taking into account the woman's preference. Support the decision she makes.' (recognising the roles of both the woman and the doctor in this dialogue).	Thank you for this comment. We have amended the wording of the recommendations to say that decisions on timing and mode of birth should be based on the woman's preference and obstetric indications to reflect that the woman's preference should be the basis for the discussion and shared decision making. We decided not to add "support the decision she makes" as this should be standard practice and it is outlined in the NICE guideline on patient experience in adult NHS services (CG138) (see recommendation 1.3.8 in CG138 "Respect and support the patient in their choice of treatment, or if they decide to decline treatment") which we have added a reference to earlier in the guideline in relation to information sharing and shared decision making
Midwifery Unit Network	Guideline	27	7 and 11	MUNet notes apostrophe correction needed – weeks' not weeks	Thank you for this comment. The typographical error has been corrected
Midwifery Unit Network	Guideline	27-28		Section 1.9 Obesity MUNet is disappointed that the Committee did not incorporate any reference in its discussions to the NPEU study on the 'impact of maternal obesity on intrapartum outcomes in otherwise low risk	Thank you for this comment. Place of birth is outside the scope of this guideline. The scope of the section on obesity focused on specific review questions: assessing fetal presentation in early labour; fetal monitoring during labour; use of ultrasound for assessing needle siting for

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				women: a secondary analysis of the Birthplace national prospective cohort study.' https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/1471-0528.12437 MUNet is concerned that the draft recommendations on care of obese women will have an unfortunate impact on individualised care planning, as together they imply that women with a raised BMI can only be cared for safely in an Obstetric unit, yet evidence is emerging that this is not the case. With individualised risk assessment and care planning, it may be that some women who are obese can give birth safely outside the Obstetric unit. MUNet is aware that a UKMidSS study (Study 1 Severe obesity) will be published soon and urges NICE to contact NPEU/UkmidSS to discuss making findings available to NICE and the Committee ahead of publication to inform these recommendations. Further comments: 1.9.1 MUNet does not agree that the Committee has grounds for making a recommendation with unqualified wording ('consider' will be read in maternity services as a stronger recommendation than it is) that will promote bringing scanning technology into the birthing room without evidence that this improves outcomes. We suggest 'For women with a BMI over 30 kg/m2 at the booking appointment, particularly those with a BMI over 35 kg/m2, make an individualised care plan with the woman at the start of established labour, and consider ultrasound scanning at that time if the baby's presentation	central neuraxial blockade; optimal position in the second stage of labour; and additional equipment needed to ensure optimal care. The Birthplace national prospective cohort study publication (Hollowell 2013) is not relevant for these questions. Upcoming publications will be considered when NICE conducts regular surveillance reviews to assess whether the guideline needs updating. The recommendations specifically encourage individualised care planning and risk assessment, and do not assert that women with a raised BMI should be cared for in an obstetric unit. The recommendations also aim to ensure that where special measures, such as size-appropriate equipment, is needed this would be available to the woman. In relation to recommendation on considering ultrasound scan, a scan should only be considered when the baby's presentation is uncertain. In clinical practice this applies to all women, however, in women with BMI over 30 it might be more common to have uncertainty about the baby's presentation. We do not want the recommendation to prevent women with a BMI 30-35 from giving birth in midwife-led unit if that is what she prefers. The suggested edits to the recommendation is covered by other recommendations in the guideline, particularly recommendations in the section on information for women with existing medical conditions

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				is uncertain. Advise the woman that there is no evidence to indicate whether a scan at this point is helpful and improves outcomes, or not. Inform her about any NICE recommendations and/or research evidence relevant to her individual situation that could inform her decision about birth setting, as well as making her aware of recommendation 1.1.10 in NICE CG190 regarding place of birth.' 1.9.2 is unclear – what does 'Obstetric indications' mean? The wording is ambiguous and appears to suggest that CTG is being recommended. In practice, some women will receive midwife led care in a midwifery unit, others midwifery care in an Obstetric unit, but the implication of the recommendation is that there will automatically be Obstetric care. MUNet suggests simply referring to CG190 (in line with the rationale in the evidence review). We suggest, 'For women with a BMI over 30 kg/m at the booking appointment and no medical complications, advise the woman that there is uncertainty about whether electronic fetal monitoring is a better way to monitor the baby's heartbeat than intermittent auscultation, and take into account her preference (explaining to her NICE CG190 recommendations 14.7, 1.4.8 and 1.10.7, if she requests cardiotocography). Offer monitoring as in the NICE guideline on intrapartum care for healthy women and babies, taking into account findings on initial assessment and during ongoing assessment.'	
Midwifery Unit Network	Guideline	28	17	1.9.5 MUNet again notes that the Guideline is for women as well as for professionals, and a woman at low risk of complications making decisions about her labour and birth is 'receiving care', not 'being	Thank you for this comment. We agree and have made the change suggested

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				managed': 'managing' someone suggests a power relationship. While there is an inequality of knowledge and action in providing clinical care, to frame the relationship in this language does affect culture in services, and that in turn can lead to breakdown of trust in relationships where women who are vulnerable (e.g. previous controlling /abusive/ traumatic experiences) will feel unable to speak up, when given very directive recommendations about their care. Respectful language is to be preferred here, and in the rest of the Guideline. We suggest 'For women with a BMI over 30 kg/m2 at the booking appointment and adequate mobility, provide care in the second stage of labour in line with the NICE guideline on intrapartum care for healthy women and babies.'	
Midwifery Unit Network	Guideline	28	7to13	1.9.3 MUNet notes that there is no reference in this recommendation to planning place of birth – see pervious comment including a Birthplace/NPEU reference and UKMidSS.	Thank you for this comment. Place of birth was not in the scope of this guideline. The scope of the section on obesity focused on specific review questions: assessing fetal presentation in early labour; fetal monitoring during labour; use of ultrasound for assessing needle siting for central neuraxial blockade; optimal position in the second stage of labour; and additional equipment needed to ensure optimal care. The referenced publications were not relevant for these questions. However, intrapartum care planning would certainly include a plan about the place of birth among other things (see section on planning for intrapartum care with women with existing medical conditions – involving a multidisciplinary team)

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Midwifery Unit Network	Guideline	28	9	1.9.3 Midwifery Unit Network MUNet supports a human rights focused approach to shared decision making in pregnancy, labour and birth. We therefore suggest that this recommendation needs to refer to the woman's role in co-creating her the birth plan where advice about that plan is being offered. While appreciating that a recommended 'offer' or suggested plan is the start of a discussion between the woman and those caring for her, MUNet's view is that it is helpful to state that the woman is involved. We therefore propose the wording here should be changed to 'and when developing the birth plan with the woman, take into account:'	Thank you for this comment. We have made the change suggested
Midwifery Unit Network	Guideline	29	13-15	1.9.8 MUNet suggests that an acknowledgement should be added here that women with high BMI often feel judged by the language used about and to the and by plans to 'manage' their care, and that protecting their mental/emotional health involves taking care with this conversation – we suggest 'offer referral to an Obstetric unit with suitable equipment and expertise…[as drafted]..not available in their current unit, offering an appointment with a skilled practitioner to have this discussion, recognising the sensitive nature of topic of BMI for many women with a high BMI'. MUNet notes that relationship between high BMI and early childhood experiences remains unclear, as does work on mode of birth and later obesity: this is a topic of major interest for women and families, and society. There is a body of qualitative work examining experiences of women who are obese during pregnancy and birth, and MUNet is	Thank you for this comment. We agree that sensitive, respectful and professional language should be used by the people caring for the woman, as set out in the NICE guideline on patient experience in adult NHS services (CG138) which we have added a reference to in the information for women with existing medical conditions section. Unfortunately, the scope of this section had to be kept focused on specific topics due to the large scope of the guideline overall and we could not include all topics and types of evidence that we too consider important. However, we want to assure you that we had extensive discussions about women's experiences and the importance of sensitive, woman-centred language and approaches to her care and considered these throughout

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				disappointed given the importance of women's psychological wellbeing, as noted by the Committee, that this evidence has not been considered and taken into account in framing these recommendations abut the care of women with high BMI.	the development of this guideline, including searches for qualitative evidence about information giving
Midwifery Unit Network	Guideline	29	16	1.10 MUNet notes that some readers find the heading confusing .It might be better as 'Information for women with Obstetric complications.' Then '1.10.1 Follow the recommendations on communication in the NICE guideline on intrapartum care for healthy women and babies for women in labour with Obstetric complications and women with no antenatal care, who are treated in this Guideline as being at risk of Obstetric complications.'	Thank you for this comment. The heading and recommendation have not been changed because the phrasing reflects the scope of the guideline in which women at increased risk during labour and birth because of obstetric complications or having had no antenatal care are considered together
Midwifery Unit Network	Guideline	29	2to3	1.9.6 MUNet agrees that all Obstetric units should have 'birthing beds' able to take a safe working load of 250kg but they are not needed in Midwifery Units, where active birth is encouraged – please make this explicit. We suggest 'All Obstetric units should have 'birthing beds' able to take a safe working load of 250 kg. These are not needed in Midwifery Units, where some women with a BMI over 30kg/m2 birth by arrangement, with an individualised care plan.'	Thank you for this comment. The recommendation does not imply that midwifery units need "birthing beds" as the recommendation refers specifically to obstetric units. Therefore the suggested change has not been made
Midwifery Unit Network	Guideline	30	1to13	1.10.2-1.10.5 MUNet welcomes the woman-centred and human rights-aware language of these recommendations about communication with the woman, NICE CG138-compliant information-provision and respect for her decisions, especially recommendation 1.10.4 which does need saying, regrettably, as anecdotally (and see the work of Birthrights). At a time when services are busy and activity may be prioritised over 'listen and talk', it is important to support healthcare professionals (as well as	Thank you for this comment. The recommendations have been amended to refer to presenting information in line with the NICE guideline on patient experience in adult NHS services (CG138). The specific forms of presentation suggested by you have not been included in the recommendations because these are referenced in the patient experience guideline.

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				women) by making explicit in these recommendations exactly what the necessary, evidence-based information is. At line 7 we suggest 'expresses benefits and risk in a way that the woman can understand, in line with the recommendations of NICE CG138 patient experience in adult services – particularly absolute figures with a standard denominator, framed both ways, with various formats available whenever possible' See examples of practice in NICE CG190 section 1.1 Tables 2 and 4 And here https://www.harding-center.mpg.de/en/fact-boxes/pregnancy-and-childbirth/premature-rupture-of-membranes-prom The assumption that the birth companions 'should' be kept fully informed is wrong – see previous comments. Only with the woman's explicit consent.	The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
Midwifery Unit Network	Guideline	32	3	Table – final line. Where is the reference in the recommendations to AVPU?	The only reference is in the table to allow comparison with more severe conditions such as sepsis when the woman's level of consciousness should be monitored
Midwifery Unit Network	Guideline	33	7	Table – final line. Where is the reference in the recommendations to AVPU? (Are the tables different? It is unclear what practical purpose they serve)	Thank you for this comment. Tables 3 and 4 provide guidance on routine maternal observations to be performed for women with obstetric complications or no antenatal care. Table 3 is about routine maternal observations for women in labour with breech presentation, a suspected small- or large-for-gestational-age baby, previous caesarean section, onset of labour

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					after 42 weeks of pregnancy or no antenatal care. Table 4 is about routine maternal observations for women in labour with fever, suspected sepsis, sepsis or intrapartum haemorrhage. We have discussed the comment and we agreed that the table format facilitates cross-comparison between the different complications and so should aid healthcare professionals in providing care for these different complications. A header has now been added to both tables to clarify that the columns refer to the frequency of maternal observations. Multiple edits have also been made to both tables in response to stakeholders comments, and the frequency of assessments of the woman's level of consciousness (using the "alert, voice, pain, unresponsive" (AVPU) framework) has been edited. Moreover, table 3 now makes it clearer that assessment of the woman's level of consciousness it not required routinely for the complications covered by this table. The frequencies documented in the tables are not repeated elsewhere, so the only reference to AVPU assessment is in these tables
Midwifery Unit Network	Guideline	36	11	1.13.9 MUNet supports a human rights aware approach in maternity which involves changing outdated practice and supporting true shared decision-making by repeatedly modelling 'how things should be' through better choices of language: unless the woman is critically ill, it is she who will decide on timing and mode of birth, by giving consent or otherwise to what is proposed to her. MUNet	Thank you for this comment. The wording has been amended to refer to "discussing" with the woman rather than the possibility of "deciding" on her behalf

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				therefore suggests 'When recommending timing and mode of birth to the woman, take into account:'	
Midwifery Unit Network	Guideline	36	4	1.13.8 MUNet notes that the Guideline is for women as well as for professionals, and suggests that involving the woman in 'shared decision-making about her care' is preferable to 'management'.	Thank you for this comment. We agree and have made the change suggested
Midwifery Unit Network	Guideline	38	13	1.13.20 MUNet supports the provision of support to healthcare professionals who correctly respect and support a woman in her continuing care, even if she makes a decision that is contrary to what has been recommended to her, as well as being committed to supporting women's informed decision making in pregnancy, labour and birth. We therefore suggest, for clarity, avoiding the somewhat ambiguous word 'choice' (a choice can be something you would 'like to have', rather than a thing that 'has been decided') and using the word 'decision' instead – so 'and support the decision she has made, to accept or decline testing'	Thank you for this comment. We have altered wording as suggested
Midwifery Unit Network	Guideline	39	20	1.13.26 MUNet suggests 'support to enable the woman to feed her baby as she decides…'	Thank you for this comment. We considered the issue carefully and decided to retain the phrase 'as she chooses' because this was thought to best represent the circumstances the recommendation is intended to cover
Midwifery Unit Network	Guideline	41	2to8	1.14.5 MUNet suggests adding an additional bullet point to the list of people involved in agreeing the plan for her care: 'the woman' – the 'explain what is happening' at 1.14.8 is likely to be sufficient only where care provision is immediate and urgent	Thank you for this comment. We have altered the wording to refer to involving the woman in agreeing and documenting a multidisciplinary care plan
Midwifery Unit Network	Guideline	42	14-18	MUNet would like to see absolute figures, frames both ways, tabulated in the Guideline to help busy professionals to provide the specified information in an unbiased way: tabulating the figures will	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the

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				encourage services to create decision aids, as has happened following NICE CG190 (planning place of birth section)	evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
Midwifery Unit Network	Guideline	42	6to13	1.15 MUNet is committed to supporting the provision of unbiased, evidence-based information to women in the manner specified in NICE CG138, and supporting healthcare professionals in taking that approach. The wording of this recommendation might incorrectly be used as a 'script' in discussions with women –it is crucial to be explicit that absolute figures, framed both ways should be part of the discussion: this is not obvious to many professionals in practice, and women's expectations are unlikely to change until services in general do have modern, evidence-based practice in this regard. Please draw up and include the relevant two-way table in the recommendation.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about

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					outcomes that would tend to occur more or less often with certain interventions
Midwifery Unit Network	Guideline	44	5to15	1.17.2 MUNet is committed to supporting the provision of unbiased, evidence-based information to women in the manner specified in NICE CG138, and supporting healthcare professionals in taking that approach. The wording of this recommendation might incorrectly be used as a 'script' in discussions with women –it is crucial to be explicit that absolute figures, framed both ways should be part of the discussion: this is not obvious to many professionals in practice, and women's expectations are unlikely to change until services in general do have modern, evidence-based practice in his regard. We do not think that general reference to CG138 at the beginning of the guideline would have the same effect. Please draw up and include the two-way table showing the figures in the recommendation.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
Midwifery Unit Network	Guideline	45	25	1.18.4 final bullet point add 'and/or social services'	Thank you for this comment. The suggested change has been made
Midwifery Unit Network	Guideline	46	10	1.18.8 MUNet considers that limiting the offer of rapid HIV testing only to those 'thought to be at high risk of infection' will lead to stigmatising some women and missing others. This judgement, which should not take place in a hurry, relies on subjective and biased assumptions about others who possibly appear 'too nice' to have been in any situation of risk other than not presenting for antenatal care – which in itself might flag being in a risk category	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis. However, we decided that the health economic considerations underpinning the recommendation for rapid HIV testing remained valid. The health economic evidence suggested that rapid HIV

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				that is not otherwise immediately apparent. As no one knows for certain their sexual partner's history, it should be offered to those women without an HIV result in the notes, those who want repeat testing (from booking) or all those at continuing risk (i.e. iv drug use, heterosexual sex)	testing could cease to be cost effective when HIV prevalence is very low. Therefore, we considered it would be cost effective to recommend rapid HIV testing in a context where prevalence would be higher than would result from no antenatal care alone. We are aware that rapid HIV testing services are not yet available throughout the NHS and we did not think the evidence was substantially robust to make a recommendation that would require a rapid HIV testing service to be established even when HIV prevalence is very low
Midwifery Unit Network	Guideline	47 and 48	8-24 and 1-2, 6-9	1.19.2-4, 1.19.7 Again MUNet would like to see explicit reference to giving evidence-based information compliant with NICE CG138 rec 1.5.24: absolute figures, standard denominator framed both ways, variety of formats available etc. We do not think that general reference to CG138 at the beginning of the guideline would have the same effect.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about

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					outcomes that would tend to occur more or less often with certain interventions
Midwifery Unit Network	Guideline	48	22-23	1.20.1 MUNet suggests inclusion of a two-way table in this recommendation*, giving the figures for the risks of stillbirth, framed both ways, and with a standard denominator (NICE CG138 rec 1.5.24). It is important to offer women a choice, based on unbiased, evidence-based information, rather than 'custom and practice' – if women are simply told 'there is an increased chance of stillbirth' then they are subjected to implicit societal pressure (if not any pressure within the maternity service, as such), to 'do the right thing' and accept intervention, without having actually made an informed decision.' *if NICE considers it cannot include the figures because the evidence has not been reviewed, then set out the table format. Say '...explaining with reference to information based on the format in Table T below that there is an increased chance of stillbirth etc..' and include a two-way table with blank boxes labelled 'add figure' and 'add denominator'.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
Midwifery Unit Network	Guideline	48	4to5	1.20.3 MUNet welcomes the recommendation about information-giving but is concerned that it is incomplete. MUNet believes that there is no clear evidence that the increased risk of instrumental birth and caesarean section is causally linked to improved neonatal outcomes in this group of women – It is highly likely that it is a confounded association, and that the neonatal outcomes have improved thanks to neonatal improvements, not the birth itself. The outcomes might even have been better without some of the surgical	Thank you for this comment. We have discussed this and agreed to delete this recommendation because it is beyond the scope of the review question. The review question was about maternal and fetal monitoring, as set out in the review protocol in appendix A of evidence review T. Although this recommendation has now been deleted, we wanted to clarify in relation to the comment that we were not trying to draw an association between

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				births. For example, outcomes might be worse after a caesarean birth, when the baby is less prepared for breathing or when operator anxiety leads to early cord clamping to hand an anticipated "distressed" or "weak" baby to a neonatologist (see refs to 30% increased death/ damage in premature babies with early cord clamping.) As it is possible that the increased rate is related to the anxieties of caregivers: women should be told this too. This may be particularly relevant information for women exploring the possibility of birthing in a midwifery unit, rather than choosing the Obstetric unit. Also, why is NICE proposing this recommendation without having considered the relevant evidence? This is most unsatisfactory and needs to be flagged clearly in the recommendation.	mode of birth and neonatal outcomes. The recommendation outlined the increased risk of instrumental birth and caesarean section for women in labour after 42 weeks of pregnancy. In the consultation draft version of evidence review T, in the committee's discussion of the evidence section, it was explained that this recommendation was based on the committee's knowledge and experience, as well as being informed by some descriptive data in the NICE guideline on inducing labour (CG70). Table 4.1 on page 25 of the full version of the inducing labour guideline reports descriptive data on maternal outcomes by week of pregnancy and is based on studies conducted in several different countries. The table shows a higher incidence of caesarean section and haemorrhage of more than 500 ml after 42 weeks of pregnancy compared to births at earlier gestational ages; these findings were based on a study conducted in Denmark. The table also shows a higher incidence of instrumental vaginal births at 42 weeks of pregnancy compared to births at earlier gestational ages; these findings were based on studies conducted in Norway, the USA and Israel. However, the inducing labour guideline does not provide an assessment of the statistical significance or clinical importance of the reported differences. This whole explanation has now been deleted from the discussion of the evidence section, in line with the deletion of the recommendation

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Midwifery Unit Network	Guideline	5	10to 12	1.1.2 MUNet welcomes the recognition of the need for extra time to allow for proper individualised care planning for women with existing medical conditions	Thank you for this comment in support of the guideline
Midwifery Unit Network	Guideline	5	12	1.3.3 are at low risk of what? For clarity MUNet suggests 'at low risk of complications'	Thank you for this comment. We have amended the wording of the recommendation as suggested
Midwifery Unit Network	Guideline	5	13	1.3.3 again, MUNet notes that the Guideline is for women as well as for professionals, and a woman at low risk of complications making decisions about her labour and birth is 'receiving care', not 'being managed': respectful language is therefore 'at low risk of complications and their care should be in line with etc' Managing' someone suggests a power relationship. While there is an inequality of knowledge and action in providing clinical care, to frame the relationship in this language does affect culture in services, and that in turn can lead to breakdown of trust in relationships where women who are vulnerable (e.g. previous controlling /abusive/ traumatic experiences) will feel unable to speak up, when given very directive recommendations about their care. Respectful language is to be preferred here, and in the rest of the Guideline.	Thank you for this comment. We have amended the wording of the recommendation as suggested
Midwifery Unit Network	Guideline	5	18	1.1.4 MUNet notes that the Guideline (page 1) is for women and families as well as for professional and commissioners - 'presents' in this recommendation is unclear in meaning for women/families. MUNet suggests 'as soon as she first has contact with healthcare services in her pregnancy'	Thank you for this comment. We have amended the wording of the recommendation as suggested
Midwifery Unit Network	Guideline	5	3	Midwifery Units Network ('MUNet') is pleased to note the use of the terminology 'women and their birth companions', consistent with NICE CG190, as this keeps the focus on the woman as the person who must take decisions and give consent to recommend	Thank you for this comment in support of the guideline. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to

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				interventions, while acknowledging the importance to many women of their life partner and/or supports or birth partners, if any, in pregnancy and birth.	clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
Midwifery Unit Network	Guideline	5	3to9	1.1.1 MUNet thinks it is important to flag in this recommendation the recommendations in NICE CG138 on provision of evidence-based information, especially recommendation 1.5.24, as this is guidance not well-known and not often followed fully in practice cf. lines 6-9, draft recommendation (1.2.1)	Thank you for this comment. We have added a reference to the NICE guideline on patient experience in adult NHS services (CG138) in various parts of the guideline, recognising the importance of the issues raised by you and in CG138
Midwifery Unit Network	Guideline	5	9to11	1.2.1 MUNet welcomes the positive reference to an individualised plan. However, we are is concerned by the possible implication that birth companions as well as the woman are automatically involved in shared decision-making. This is incorrect – 'my body, my consent': the decision is the woman's. The woman may wish to involve any birth companions, of course. A small proportion of women are in violent and coercive relationships, and pregnancy is a time when violence is known to appear or escalate. It is wrong for health professionals to risk breaches of confidentiality by an assumption of 'happy families', and	Thank you for this comment. We agree that women's birth companions should only be involved in the shared decision-making if the woman consents to it. We have added new recommendations about this. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These

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				for NICE to in any way reinforce such unconscious biases. It should be made explicit that health professionals owe a duty of confidentiality to the woman, and whenever anything is shared it is 'with permission' We suggest, 'The plan should be: [first bullet point as drafted] reviewed with the woman and (only if she wishes and gives explicit consent at each step) her birth companion(s) throughout pregnancy and on admission for birth [continue as drafted]'	recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
Midwifery Unit Network	Guideline	8	1to3	1.3.5 MUNet is not sure of the meaning here – does the Committee mean that investigation results should be 'promptly shared' (in which case please make it clear) or that investigations should be carried out in cases of suspected heart disease and pregnancy not used as a 'reason' to deny access to those investigations? In which case, 'Ensure that diagnostic investigations are offered and recommended to women with heart disease as they would be were the woman not pregnant and that the results etc'	Thank you for this comment. We agree that the wording of this recommendation should be changed to ensure clarity. As you state, we do not want suspected heart disease, or pregnancy, to result in denial of specific investigations; therefore, the recommendation has been amended as suggested
Midwifery Unit Network	Guideline	8, 9, 10	5-26 and 1-19 and 1-2	1.3.8-1.3.13 MUNet finds the order of the recommendations confusing here – the logical and woman-centred flow would be pregnancy, labour, birth, postnatal, but the recommendations dot around in a way that encourages the 'compartmentalisation' approach, of seeing people as their 'diseases'. Surely 1.3.12 should come first as the new 1.3.8? Existing 1.3.8 and 1.3.9 should be reversed etc – from a woman-centred perspective, there should always be a plan for threatened or actual labour, as women might have premature show or contractions, and the order of recommended interventions should reflect the time order of possible	Thank you for this comment. The recommendations in this section have been re-ordered and re-structured in what we agree is a woman-centred perspective

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				interventions – so induction of labour before caesarean. Our experience is that this makes both reading a Guideline and using it easier when plans are devised with women in practice.	
Midwifery Unit Network	Guideline	90	15	Regarding labour after 42 weeks of pregnancy, MUNet suggests 'explaining' rather than 'emphasising' the 'increased risk of stillbirth in these circumstances' since 'emphasising' can, in practice, cross a threshold into coercion. The absolute risks involved are arguably small – and the assumption that the speaker or the woman 'should' hold and react to those risks in any particular way is incorrect. There is an important distinction between recommendations made in relation to a population of childbearing women (NICE guidance on induction for 'dates') and the situation of an individual woman making her own decision based on the trade-offs that feel right and important to her, in discussion with the healthcare professionals caring for her. Women are entitled to unbiased, evidence-based information in NICE CG138 compliant formats, and a starting assumption in listening to them, and discussing the matter with them, that they may hold any one of a range of views about what any given level of risk, and any given increase in risk, means for them (the mother and her baby), set against other relevant considerations that come with benefits and risks.	Thank you for this comment. The original "emphasising" was included in part to avoid have repeated use of the verb "explain" in the same sentence and we agree with the points made by you. However, in light of other stakeholder comments the corresponding recommendations have been revised to such an extent that the sentences referred to in this comment have been deleted completely from the rationale and impact section
Midwifery Unit Network	Guideline	91	2to24	MUNet suggests that the language here may lead to unfortunate labelling of women themselves as 'high risk women', implying a level of danger affecting a large grouping of women in a way that may be out of proportion to the probabilities involved for subgroup(s) of them. (cf Better Births review, which suggests that individualised care is to be emphasised rather than generic risk	Thank you for this comment. We have amended the text in this section to emphasise the importance of individualised care in risk assessment and planning. This section defines "high risk" as a risk higher than in the "normal population" and is intended to distinguish the population in this guideline from the population of "healthy

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				categorisation). MUNet suggests at lines 2-3 'Risk assessment and planning are key components of individualised care for pregnant women, so that any factors likely to have a negative impact on the pregnancy or birth can be identified in a timely manner. This Guideline deals with care of women at higher risk of complications in pregnancy and birth, either because of an existing medical condition or because Obstetric complications develop. With appropriate risk assessment and care planning, care can be delivered to maximise the chances etc [continue as drafted, from end of line 4]' Lines 22-24 amend to: 'a woman can enter labour with no identified complications and be considered at low risk of complications, but problems may arise during labour that can be associated with adverse outcomes.' The Committee is invited to consider NICE CG190 recommendation 1.1.13 and to be guided by it in the process of finalising this Guideline wording: 'Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth.' While 'risk labelling' can be easy shorthand jargon when describing groups of care pathways in services, unhelpful consequences can include some staff failing to see the individuality of the woman receiving care, and a possibility that a clinician or a service will	women and babies" in the NICE guideline on intrapartum care for healthy women and babies (CG190). Whilst recognising your concerns we think this is appropriate in this context as the population covered by the guideline often requires care over and above that recommended in CG190. However, a number of recommendations also recognise that individualised care and risk assessment mean that it will be appropriate for some women to be cared for as per the recommendations in CG190. The amendments made in response to stakeholder comments incorporate the suggestions related to lines 22 to 24

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				assume 'lots of risk' or 'little risk' in any given case rather than making a properly individualised risk assessment.	
Mumsnet	Guideline	10	16	Benefits and risks of assisted second stage ought to be explained in full as well. Both caesarean sections and assisted births carry benefits and risks. These should be made clear.	Thank you for this comment. We agree with you and have amended the recommendation so that it is clear that there are potential benefits and risks with both procedures
Mumsnet	Guideline	23	17-18	Benefits and risks of assisted second stage ought to be explained in full as well. Both caesarean sections and assisted births carry benefits and risks. These should be made clear.	Thank you for this comment. We have amended the recommendation to say that benefits and risks of assisted second stage of labour as compared to active pushing alone should be explained
Mumsnet	Guideline	43-44	20-23; 1-18	This recommendation is to be welcomed in itself, but Mumsnet users feel strongly that information about comparative risks must also be given to women before they are in labour. Self-evidently, labouring women are not always in the best state of mind to weigh up the risks and benefits of different approaches. This information must be given clearly during antenatal appointments, as per recommendation 1.1.2. It would be welcome if the Guidance could make it clear that truly informed consent will involve prior discussion wherever possible.	Thank you for this comment. We agree that information about comparative risks should ideally be given in the antenatal period. However, it is beyond this guideline's remit to provide guidance for information giving in the antenatal period. We hope that practitioners will note the recommendations and draw on them in relation to information giving in the antenatal period. With regard to the aspect of the comment that refers to consent, we agree with the importance of the woman having an opportunity to provide informed consent, and that this would be facilitated by having information before labour and birth. However, this review also covers women in labour who have not previously been recognised as having a suspected large-for-gestational-age baby. The wording "offer" in a later recommendation implies that the woman's consent would be needed to agree an informed decision on mode of birth

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Mumsnet	Guideline	47	16-18	Is there evidence for this statement? In particular, is there evidence that focuses on the outcomes for babies born via emergency section vs planned sections? If so, could it be cited? If not, should the statement be reviewed?	Thank you for this comment. The comparison between emergency caesarean section performed in labour versus planned caesarean section performed before labour was not included in the review protocol in appendix A of evidence review S because this guideline only focuses on women in labour, and so the population in the review protocol is women in the first or second stage of labour with 1 or more previous caesarean sections. The only comparison included in the protocol in relation to mode of birth was emergency caesarean section versus continuation of labour. This recommendation only refers to women in labour and does not make any reference to a planned caesarean section occurring before labour. The review protocol in appendix A of evidence review S states that evidence related to women who were in labour but had planned an elective caesarean section should be reviewed and analysed separately. However the available evidence did not allow separation of results for this subgroup. Therefore, the recommendations did not make a distinction between women in labour who had planned an elective caesarean section or women in labour who had planned a vaginal birth. We agree that the recommendations would be applicable to both groups of women. There was evidence on outcomes for the baby for the comparison emergency caesarean section versus continuation of labour; please refer to the evidence

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					statements in evidence review S. All the evidence was of very low quality. There were multiple adverse outcomes considered. For most outcomes, there was no clinically important difference between babies born vaginally and babies born via an emergency caesarean section or there were no adverse events in either group therefore due to zero events no risk estimates could be calculated. For two adverse outcomes, the incidence was lower in babies born vaginally compared to babies born via an emergency caesarean section and the difference was clinically important. Having considered this evidence, we agreed that it was important that women in labour with previous caesarean section should be made aware that there is no compelling evidence to recommend one mode of birth over another to improve outcomes for the baby
Mumsnet	Guideline	6	13-14	Service users would find it reassuring to know which healthcare professional is coordinating/managing their MDT	Thank you for this comment. We agree with this but it is covered in an earlier recommendation which recommends having a multidisciplinary team led by a named healthcare professional
Mumsnet	Guideline	General	General	Mumsnet users are surprised that diabetes is not specifically mentioned in the Guideline. If there is separate Guidance, should that be signposted?	Thank you for this comment. Diabetes is outside the scope of the guideline because there is an existing NICE guideline on diabetes in pregnancy (NG3). Supplement 1 (Development of the guideline and methods) notes that diabetes in pregnancy is outside the scope of the guideline and the scope itself (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2) provides a

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					rationale for its exclusion from the guideline and a link to the diabetes in pregnancy guideline (https://www.nice.org.uk/guidance/ng3). However, the NICE guideline on diabetes in pregnancy (NG3) is now signposted at the end of the recommendations about information for women with existing medical conditions
Mumsnet	Guideline	General	General	A few Mumsnet users also commented that hypermobility (Elhers Danlos Syndrome) is not covered by this Guideline. They say there is a general lack of guidance for pregnancy and labour when it comes to hypermobility. Could this omission be rectified? If there is separate Guidance, could it be signposted?	Thank you for this comment and for raising this issue. It was not possible to include every medical condition not covered by other NICE guidance within this guideline. A thorough scoping exercise was undertaken prior to guideline development in order to determine what topics and areas should be covered. As part of this scoping exercise stakeholders were invited to attend a workshop to discuss the draft guideline scope. In addition stakeholders were given an opportunity to comment on a revised draft of the scope. No comments were received on the omission of Elhers Danlos Syndrome (EDS) from the draft scope of the guideline. As EDS was not included in the final scope of the guideline (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2) it is not possible to include it at this stage. There are no separate NICE or NICE accredited guidelines in this area. We are aware that some researchers have recently raised the issue of a lack of any management guidelines for EDS pregnancies (https://www.magonlinelibrary.com/doi/full/10.12968/bjom.

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					2018.26.4.217) and therefore it may be addressed in future NICE guidelines
Mumsnet	Guideline	General	General	Some Mumsnet users have also queried why previous stillbirth is not mentioned as a high-risk factor. Again, could this be rectified or other Guidance signposted? One user who has experienced stillbirth said: '[Women with previous stillbirths have an] increased need for privacy and for a partner to be able to stay with the labouring woman. I had to get a private room in order to have my partner with me while being induced.'	Thank you for this comment. The main focus of the guideline was intrapartum care for women with existing medical conditions and obstetric complications in the current pregnancy. The number of possible medical conditions and obstetric complications meant that it was not feasible to include everything in this guideline and the priorities for inclusion were those medical conditions and obstetric complications that result in high mortality or morbidity which can be reduced through high-quality intrapartum care. A thorough scoping exercise was undertaken prior to guideline development in order to determine what topics and areas should be covered. As part of this scoping exercise stakeholders were invited to attend a workshop to discuss the guideline scope. In addition stakeholders were given an opportunity to comment on a revised draft of the scope. No comments were received to suggest that previous stillbirth should be included within the scope of the guideline. There is no other NICE guidance that can be signposted although we do think that the following recommendation would be relevant to women with a previous stillbirth: 1.10.5 Involve the woman in planning her care by asking

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					about her preferences and expectations for labour and birth. Take account of previous discussions, planning, decisions and choices, and keep the woman and her birth companion(s) fully informed
Mumsnet	Guideline	General	General	One Mumsnet user with spina bifida questioned why her condition is not covered in the Guideline. If there is separate Guidance, should that be signposted?	Thank you for this comment. It was not possible to include every medical condition not covered by other NICE guidance within this guideline. A thorough scoping exercise was undertaken prior to guideline development in order to determine what topics and areas should be covered. As part of this scoping exercise stakeholders were invited to attend a workshop to discuss the guideline scope. In addition stakeholders were given an opportunity to comment on a draft version of the scope. No comments were received on the omission of spina bifida from the draft scope of the guideline. There are no separate NICE or NICE-accredited guidelines in this area that can be signposted
National Childbirth Trust (NCT)	Document C	88	20-22	The text says: "Women with preload dependent circulation are particularly vulnerable to falls in blood pressure and there is some evidence to suggest that oxytocin should be given as an infusion rather than bolus to avoid sudden drops in blood pressure." yet the outcomes reported in lines do not seem to include hypotension or blood pressure. Also the outcomes assessed all seem to eb very low quality – so the findings are very uncertain. Maybe there is evidence for women without heart disease in which case it would help to report this.	Thank you for this comment. The evidence identified for this review question only provided data on postpartum haemorrhage, and so we do not have blood pressure or hypotension as outcomes; however we used our clinical knowledge to agree an accepted risk of sudden falls in blood pressure with oxytocin, hence the inclusion of a statement regarding the importance of using slow infusion oxytocin. The review is specifically focused on women with heart disease; therefore, it is not within the scope of

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					the review to include data about women without heart disease
National Childbirth Trust (NCT)	Draft Document O 'Evidence for breech presentation in labour'	27	5to10	"Why the committee made the recommendations Evidence showed an increase in maternal infection and other maternal complications during the first 6 weeks after caesarean section in labour for breech presentation compared with vaginal breech birth. Evidence showed fewer adverse outcomes for the baby after caesarean section in early labour for breech presentation compared with vaginal birth, but the benefit was less clear when caesarean section was performed in the later stages of labour." The evidence on all the outcomes for women and babies in these evaluations are 'very low quality' or 'very low certainty' which means 'The estimate of effect is very uncertain' (Supplement 1 page 24). So it is unclear if the intervention improves the outcome or not. So we believe the statements here should make this clear and we suggest: Very low quality evidence means there is uncertainty as to whether there is an increase or decrease (or no difference) in maternal infection and other maternal complications during the first 6 weeks after caesarean section in labour for breech presentation compared with vaginal breech birth. Very low quality evidence means there is uncertainty as to whether	Thank you for this comment. We have discussed this and agreed that the recommendations are not only based on evidence but also the committee's experience. We have now specified in the rationale and impact section that the evidence was in line with the committee's experience. This is also highlighted in the discussion of the evidence section, which mentions that the committee recognised that some adverse outcomes could occur only with a vaginal birth, for example, the baby's head getting stuck. The committee's discussion of the evidence section also emphasises that the uncertainty in the evidence was offset by the direction of the observed effects being consistent with the committee's experience

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				there are fewer or more (or there may be no difference) in adverse outcomes for the baby after caesarean section in early labour or later in labour for breech presentation compared with vaginal birth."	
National Childbirth Trust (NCT)	Evidence Review I	12	2to3	Recommendation 1.9.1 seems particularly misguided given that the associated research recommendation states "Should we provide a routine ultrasound scan at 36 weeks to pregnant women with a BMI over 30kg/m2?" It is unclear to us why ultrasound is recommended at the start of labour, when the research recommendation is for assessment of the effectiveness of a scan at 36 weeks of pregnancy. In addition, "the committee noted that an ultrasound scan is technically more difficult to perform in a woman with a BMI over 30kg/m2" (p13, lines 16-17). We are concerned that this recommendation will result in women in labour being restricted to an uncomfortable position for a considerable time as clinicians attempt to ascertain the baby's position through ultrasound. And we are, quite frankly, appalled that "transvaginal and/or transperineal ultrasound scanning could be used" (lines 26-27) at a time when women are so vulnerable. We appreciate that clinicians may be concerned about their inability to ascertain the baby's position; however this risk should have been discussed with women with a high BMI during pregnancy. This would also give women the	Thank you for this comment. An ultrasound scan is only recommended if the presentation of the baby is uncertain as missing a malpresentation could lead to more interventions during labour and birth and could cause adverse outcomes for the woman or the baby. In practice, this applies to all women regardless of their BMI, however, uncertainty about the baby's presentation is more common among women with a high BMI due to the difficulty of assessing it via palpation. However, the benefit of an ultrasound scan extends beyond the ascertainment of fetal presentation to include detection of intrauterine growth restriction, macrosomia and amniotic fluid abnormalities. It would therefore be pertinent to assess the effectiveness of this simple and safe intervention in the third trimester for these women. Therefore, a research recommendation was drafted to inform future updates of this guideline, since no definitive guideline on this topic has been published elsewhere. Earlier recommendations about providing information for women outlines that women should be offered information about how their condition (obesity in this case) may affect

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				opportunity to accept or decline such an intervention at a less vulnerable time, and have that decision written into their care plan.	their care during the intrapartum period. The possibility of using an ultrasound scan in early labour to ascertain the presentation of the baby (if there is uncertainty) may be part of this discussion, including the benefits and harms of using an ultrasound scan and the different methods (transabdominal, transvaginal and transperineal). As with any intervention, together with the woman, the clinician should balance the benefits and harms of the ultrasound to the benefits and harms of not using an ultrasound
National Childbirth Trust (NCT)	Guideline	10	17	*"…an assisted second stage of labour without active pushing".* *It is not clear what an '…assisted second stage…' is. If this is the use of forceps or ventouse, then we suggest the recommendation should be re-worded, for example:* *"If the woman chooses to labour rather have a caesarean section, suggest she aims not to push during second stage and that forceps or ventous may be suggested to help her give birth"*	Thank you for this comment. We agree that this recommendation should be clarified, and so it has been reworded so that it is clear that the benefits and risks of both an assisted second stage of labour and active pushing alone are discussed with the woman
National Childbirth Trust (NCT)	Guideline	10	9	*1.3.15 We suggest: "Offer planned birth (induction of labour or caesarean section) for women with mechanical heart valves in order to minimise the time off anticoagulation, but discuss with the woman as this is a suggestion from the GDG in the face of lack of research evidence." It is hard to comment as a non-clinician as there is no evidence we can assess to understand this recommendation and to understand the reason for not suggesting the women might aim for a spontaneous vaginal birth as caesarean section has a higher risk of PPH,*	Thank you for this comment. The suggested edit to the recommendation is not in accordance with NICE style. Instead, the lack of evidence on this topic is discussed in the rationale and impact section of the guideline as follows. "Evidence was very limited so the committee drew on their knowledge and experience to make recommendations." The rationale for this recommendation is also discussed in the same section as follows. "In order to minimise the time without anticoagulation, elective caesarean section or induction of labour should be offered for women with mechanical heart valves. The risks of

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					valve thrombosis cannot be overstated but this needs to be balanced against the risks of bleeding around the time of birth." Further discussion is documented in evidence review C (heart disease)
National Childbirth Trust (NCT)	Guideline	12	12	The symptoms covered here would suggest that women with an existing heart condition might find benefit from using upright positions and mobility in labour. We suggest to included as a recommendation – "to discuss positions and mobility in labour with women." There may be no direct evidence on this population, but the same is true of most of the recommendations in this guideline.	Thank you for this comment. The recommendations in this section are about diagnosing and managing heart failure in the intrapartum period, not about the mode of birth
National Childbirth Trust (NCT)	Guideline	14	4 to 7	1.3.32 There is nothing about managing stress, or self help techniques for managing pain, such as ensuring constant support from a woman's partner, family or friends, or a doula. This seems to be a major lack in the advice regarding women with heart disease. We believe this should be one of the first areas for discussion with women. All these recommendations are around anaesthesia and analgesia – so it would be really helpful to start with what the woman can do for herself, and with the help of her birth companion. We believe it is important that self-help ways of coping with pain in labour should be first on the list so; relaxation, massage, positions and mobility in labour (Jones 2012. Pain management for women in labour: an overview of systematic reviews. Cochrane Database of Systematic Reviews).	Thank you for this comment. We did not specifically review the evidence regarding self-help or relaxation and cannot therefore include a direct recommendation on this. We would like to point you to recommendation 1.3.32 which refers women to the NICE guideline on intrapartum care for healthy women and babies (CG190) which includes information on non-pharmacological analgesia

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				Suggest adding "Offer women with heart disease the same options for pain relief during labour as women without heart disease, and discuss with the woman and her birth companion the pros and cons of each. The options should include..." OR During pregnancy, prepare a plan for non-pharmacological ways of coping with pain in labour and also possible analgesia and anaesthesia for women with heart disease. This should involve a multidisciplinary team (outlined in recommendation 1.2.1). Consider including a haematologist for women on an anticoagulation regimen."	
National Childbirth Trust (NCT)	Guideline	14	8	1.3.33 We suggest using 'information' rather than 'advice'.	Thank you for this comment. We have amended the wording of the recommendation as suggested
National Childbirth Trust (NCT)	Guideline	16	2	We are concerned about Table 2 as it seems to lack the caution needed when administering any of these uterotonics for third stage of labour. There is caution suggested for carboprost and ergometrine but not for oxytocin or misoprostol. Appendix C page 91, lines 1-25 states Oxytocin is a neuropeptide hormone that causes dose-related systemic hypotension due to vasodilation. In healthy women this triggers compensatory tachycardia and an increase in cardiac output. Oxytocin can also cause chest pain, probably through coronary spasm. In cardiac disease an infusion is recommended	Thank you for this comment. We agree that uterotonics should always be given with caution, especially in the context of cardiac disease and address these concerns in the rationale and impact section of the guideline. We do not feel that this needs to be reiterated in these recommendations in which women with heart disease will be carefully monitored

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				rather than repeated boluses. If a bolus is used the maximum dose should be 5 units and it should be given slowly, for example, in 20 ml over 10 minutes or 3 units given no faster than 15 seconds. Carbetocin is a long-acting analogue of oxytocin and has a similar cardiovascular profile. Its use with cardiac conditions has not been reported. Thus, the committee discussed whether it should be avoided in preload-dependent circulation because of its long duration of action. Misoprostol is a synthetic analogue of prostaglandin E1 administered orally, rectally or vaginally. Although, it appears to be less vasoactive than other uterotonics, there have been reports of angina, myocardial infarction and stroke when it is used for termination of pregnancy (although the doses used for termination of pregnancy are much higher than would be used to manage postpartum haemorrhage). It is less effective than oxytocin in preventing postpartum haemorrhage, but may be a useful adjunct to promote uterine 1contractions when oxytocin cannot be used or when bleeding continues despite oxytocin use. Its use in the third stage of labour in women with cardiac disease has not been reported. We believe that cautionary wording about oxytocin and misoprostol needs to be added to Table 2. It is clearly a difficult decision on what might be the best uterotonic, but we feel the recommendations need to cover more specifically the cautions identified.	

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National Childbirth Trust (NCT)	Guideline	17	12 and 16	Prostaglandins for women with asthma. This seems rather a mixed group of recommendations. We suggest rather than focussing on 'prostaglandins' and wondering how they might be used, it is better to look at the issues so the revised heading might be: Choice of method of induction of labour for women with asthma and this should include mechanical methods as well as the possible use of drugs, but should link to the IOL guideline. The next heading might be Drugs for prevention and treatment of PPH in women with asthma This should link to the Intrapartum care guideline for women at low risk of complications if there is no specific evidence on women with asthma. It is unclear why Prostaglandins E1 and E2 are being recommended, as the normal drug for prevention and treatment of PPH is oxytocin. This section reads as if oxytocin should not be considered - is there a reason why this drug is not being recommended?	Thank you for this comment. The review question outlined in the scope of the guideline was specifically about the safety of prostaglandins in induction of labour for women with asthma (compared to oxytocin, amniotomy or mechanical methods, these being available to women with or without asthma) and about prostaglandins (compared to other uterotonics) for treating postpartum haemorrhage in women with asthma, not about induction of labour or treatment of postpartum haemorrhage in women with asthma as such. Only non-comparative evidence from case series was identified. The recommendations say to consider prostaglandin E1 and E2 for induction of labour and prostaglandin E1 for treating postpartum haemorrhage for women with asthma as there is no evidence that these drugs worsen asthma. Apart from prostaglandin F2 alpha, the recommendations do not exclude other means of induction of labour or treatment of postpartum haemorrhage in women with asthma but the scope of the question was specifically on the safety of prostaglandins for women with asthma. We have included some discussion of this in the section on the committee's discussion of the evidence in evidence review D
National Childbirth Trust (NCT)	Guideline	17	19	1.4.4 Maybe this "Do not offer prostaglandin F2 alpha to women with asthma	Thank you for this comment. We agree with the suggestion and have changed the order of these recommendations

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				because of the risk of bronchospasm." should go first in this section and under both these suggested headings	
National Childbirth Trust (NCT)	Guideline	18	3	1.5.1 states 'For women having a vaginal birth'. We believe this phrasing is incorrect and should read 'For women in labour' as at that point the mode of birth is unknown.	Thank you for this comment. We have amended the wording of this recommendation to "For women planning a vaginal birth..." We agree that these women might eventually have an emergency caesarean section which is covered by the next recommendation
National Childbirth Trust (NCT)	Guideline	18	3	1.5.2. Is this referring to women having an elective caesarean? If so, it needs to specify. It is unclear to us whether this point refers to elective, emergency or both.	Thank you for this comment. We have amended the wording of this recommendation to say "planned or emergency caesarean section" to clarify that this recommendation applies to both scenarios
National Childbirth Trust (NCT)	Guideline	19	20	1.6.3 We suggest it should say 'Plan as if …." As this language is frightening for women and it is unclear how large or small this risk is.	Thank you for this comment. We have made the change suggested to the wording of the recommendation
National Childbirth Trust (NCT)	Guideline	20	14-21	1.6.5 We suggest that the items on this list are reordered. Informing the neonatologist should be the first item on the list and, ideally, this should be done when the woman is first admitted to Labour Ward. Use of a scalp electrode and fetal blood sampling should be listed above the choice of delivery instrument.	Thank you for this comment. We have made the changes suggested
National Childbirth Trust (NCT)	Guideline	23	1	1.7.3 'Women's preferences' should come before 'Obstetric implications' as this helps to emphasise the desired relationship between a woman and her medical care team.	Thank you for this comment. We have made the suggested change throughout the recommendations to emphasise the importance of the woman's preferences and wishes

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National Childbirth Trust (NCT)	Guideline	23	17	1.7.6 We feel strongly that this should have been discussed and planned during antenatal care, not the intrapartum period. A plan should be in place for the appropriate response should the woman go into premature labour. This point should also include a link to CG132.	Thank you for this comment. We agree that the planning of intrapartum care, including mode of birth, for women with cerebral malformations should happen in the antenatal period, and we do not think that this recommendation suggests otherwise. We have emphasised the importance of planning in the first recommendation of this section. See also recommendations on multidisciplinary team planning and risk assessment, which would be done with the woman throughout pregnancy. We do not think the approach should differ for women in preterm labour as the risk of intracranial bleeding would be similar to those in term labour
National Childbirth Trust (NCT)	Guideline	23	19-22	1.7.7 As with 1.7.6, premature labour should be planned for. We suggest changing the wording to "For women at high risk of cerebral haemorrhage who prefer to aim for vaginal birth…". We suggest rewording line 22 to read: "to aim for no active pushing following a passive descent, with forceps offered if required."	Thank you for this comment. We have taken into consideration the suggestions and we have amended the recommendation to say women "who prefer to aim for a vaginal birth" and instead of recommending forceps without active pushing, we have amended the recommendation to say that benefits and risks of assisted second stage of labour compared to the benefits and risks of active pushing alone should be explained to the woman
National Childbirth Trust (NCT)	Guideline	26	22-23	1.8.12 Women's preferences' should come before 'Obstetric implications' as this helps to emphasise the desired relationship between a woman and her medical care team.	Thank you for this comment. We have made the suggested change throughout the recommendations to emphasise the importance of the woman's preferences and wishes

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National Childbirth Trust (NCT)	Guideline	27	14-15	1.8.16 Women's preferences' should come before 'Obstetric implications' as this helps to emphasise the desired relationship between a woman and her medical care team.	Thank you for this comment. We have made the suggested change throughout the recommendations to emphasise the importance of the woman's preferences and wishes
National Childbirth Trust (NCT)	Guideline	27	20	1.9.1 We are very surprised by this recommendation as there is no ultrasound scanning on MLUs. CG190 states that it is women with a BMI at booking of greater than 35 kg/m2 who should consider booking an Obstetric unit birth. This recommendation may prevent women with a BMI between 30-35 kg/m2 from using MLUs.	Thank you for this comment. We recommend that only if the baby's presentation is uncertain, an ultrasound scan should be considered to exclude malpresentation in order to avoid potential adverse events and additional interventions for the woman and the baby. In clinical practice this applies to all women, however, in women with a BMI over 30 it might be more common for there to be uncertainty about the baby's presentation. We do not want the recommendation to prevent women with a BMI of 30-35 from giving birth in midwife-led unit if that is what she prefers. In a situation where a woman with a BMI of 30-35 would go for a scan to ascertain the baby's position due to uncertainty of the baby's presentation she can be transferred back to the midwife-led unit
National Childbirth Trust (NCT)	Guideline	28	11	1.9.3 We suspect that asking midwives to assess a woman's mobility for labour, when no standardised measure exists as far as we are aware, will lead to unnecessary variations in care. We suggest that if this recommendation does remain, midwives should also enquire about any pregnancy-related exercise programmes women are engaging in, such as aquanatal or pregnancy yoga, and encourage the uptake of such programmes with an appropriately qualified instructor.	Thank you for this comment. This recommendation is about discussing with the woman how she will mobilise, what she finds comfortable, and what restrictions there might be. We recognise that there is no standardised metric to assess mobility, however, we think midwives should and will use common sense and clinical judgement based on their discussions with the woman. Pregnancy-related exercise programmes were not in the

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				A Research Recommendation about the utility of such programmes for women with a high BMI would also be useful.	scope of this guideline, therefore, they are not included in the recommendations or research recommendations
National Childbirth Trust (NCT)	Guideline	28	3to4	1.9.2 Women's preferences' should come before 'Obstetric implications' as this helps to emphasise the desired relationship between a woman and her medical care team.	Thank you for this comment. We have made the suggested change throughout the recommendations to emphasise the importance of the woman's preferences and wishes
National Childbirth Trust (NCT)	Guideline	30	4	1.10.3 "Provide information about care in labour and mode of birth, which…" We think this should link to CG138 on Patient experience in adult NHS services: improving the experience of care for people using adult NHS service	Thank you for this comment. We have added a reference to the NICE guideline on patient experience in adult NHS services (CG138) in various parts of the guideline, recognising the importance of the issues raised by you and in CG138
National Childbirth Trust (NCT)	Guideline	32	Table 3	This table seems to us to be unnecessary as the response and treatment to all identified risks is the same. Actions are also outlined, very clearly, in recommendations 1.11.4-6	This table has been retained as it sets out the frequency of monitoring recommended in the NICE guideline on intrapartum care for healthy women and babies (CG190) and it allows a convenient comparison with the corresponding table for more severe complications such as sepsis that require additional or more frequent monitoring. However, the table has been simplified to contain a single row as the types and frequency of monitoring are the same for all complications included in this table. The recommendations mentioned by you refer to other monitoring and so the frequencies documented in the table are not repeated elsewhere

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National Childbirth Trust (NCT)	Guideline	42	14	1.15.2 This needs clarification, as at present it seems to suggest that CS is the most appropriate option at any stage of labour including advanced second stage.	Thank you for this comment. The recommendation is to offer women in labour with breech presentation a choice between continuing labour and caesarean section so it does not state that a caesarean section is the most appropriate option. This recommendation has now been moved below all other recommendations on discussions with the woman, so that the woman can make an informed decision. One of these recommendations recommends explaining to women in labour with breech presentation that any benefit of caesarean section in reducing the chance of complications for the baby may be greater in early labour. The discussion of the evidence section mentions that based on the composite adverse perinatal outcome, the Term Breech Trial showed clinically important benefits for the baby from a caesarean section in early labour but only a possibility of clinically important benefits for the baby from a caesarean section in active labour. The committee debated whether there should be 2 separate recommendations, one for labour that is not yet established and one for established labour, but they noted that there is a continuum of risk for the baby over time. They also noted that if the baby's presentation were quite low in more advanced labour then performing a caesarean section could be problematic. Therefore the committee recommended advising women that any benefit of emergency caesarean section in reducing the chance of complications for the baby may be greater in early labour. Moreover, a recommendation has

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					been added to the section on risk assessment for women with obstetric complications or no antenatal care, which recommends taking account of the whole clinical picture when discussing options for care with the woman during the intrapartum period
National Childbirth Trust (NCT)	Guideline	42	16	1.15.3 "Advise women in labour with breech presentation that any benefit of caesarean section in reducing the chance of complications for the baby may be greater in early labour." The evidence to support this recommendation appears to have come from the indirect comparison of the evidence from 'Emergency caesarean section in early labour versus continuation of labour' and 'Emergency caesarean section in active labour versus continuation of labour' and this has been assessed as 'very low quality' evidence (as per Appendix O). We understand that this means the finding can go either way or there is no difference – the recommendation should reflect this. Using the word 'may' we feel is insufficient to cover the lack of good evidence in answering this question. So, we suggest using similar wording as 1.15.2 so: "Discuss with women that, if a CS is needed, the research evidence is unclear on whether doing the CS early or later in labour is better"	Thank you for this comment. We have discussed this and agreed that very low quality evidence means that the estimate of effect is very uncertain, as explained in supplement 1 (development of the guideline and methods). We also agreed that this recommendation is not only based on evidence but also on the committee's experience. Therefore, we have now specified in the rationale and impact section that the evidence was in line with the committee's experience. The discussion of the evidence section mentions that based on the composite adverse perinatal outcome, the Term Breech Trial showed clinically important benefits for the baby from a caesarean section in early labour but only a possibility of clinically important benefits for the baby from a caesarean section in active labour. The committee debated whether there should be 2 separate recommendations, one for labour that is not yet established and one for established labour, but they noted that there is a continuum of risk for the baby over time. They also noted that if the baby's presentation were quite low in more advanced labour then performing a caesarean section could be problematic. Therefore, the committee recommended advising women

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					that any benefit of emergency caesarean section in reducing the chance of complications for the baby may be greater in early labour
National Childbirth Trust (NCT)	Guideline	42	6to13	1.15.1 Breech We recognise that the situation of identifying a breech presentation during labour is different from antenatal identification, but the discussion still needs to begin during pregnancy with further discussion during labour when the situation has been assessed. So this needs to be included in the 'Plan for labour' made during pregnancy.	Thank you for this comment. We agree that provision of evidence-based information and discussion about planning labour and birth are important considerations during the antenatal period. However, the scope of this guideline is intrapartum care, and therefore inclusion of discussion relevant to antenatal care is outside the scope of the guideline, although we hope that healthcare professionals providing antenatal care will draw on the content of this guideline to guide information sharing. In the committee's discussion of the evidence section, it is highlighted that women with breech presentation may have received different information during pregnancy than in labour given that the balance of risks to the woman and baby may change with different considerations coming into play when the woman is in labour. The provision of information and discussion with healthcare professionals regarding the likely benefits and risks was, however, also noted in this context as important in enabling women to make an informed choice about mode of birth
National Childbirth Trust (NCT)	Guideline	42	6to13	1.15.1 Breech We strongly suggest a 'Facts Box' decision aid to help the antenatal discussion on this issue, containing actual rates of wellness and injury in both mothers and their babies.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the

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					evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
National Childbirth Trust (NCT)	Guideline	43	9	Rather than this statement "…it is sometimes difficult to be certain the suspicion is correct until the baby is born.." we suggest saying: "…the assessment of a baby's weight is not accurate in late pregnancy."	Thank you for this comment. The wording has not been changed because the original phrasing is more relevant to assessment during labour rather than assessment in "late pregnancy" (and this is a guideline that focuses on intrapartum care)
National Childbirth Trust (NCT)	Guideline	44	5	1.17.2 Again, add to antenatal discussions.	Thank you for this comment. The scope of this guideline was intrapartum care, and therefore inclusion of discussion relevant to antenatal care was outside the scope of the guideline, although we hope that healthcare professionals providing antenatal care will draw on the content of this guideline to guide information sharing
National Childbirth Trust (NCT)	Guideline	44	1	Ditto comment above	Thank you for this comment. The wording has not been changed because the original phrasing is more relevant to assessment during labour rather than assessment in "late

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					pregnancy" (and this is a guideline that focuses on intrapartum care)
National Childbirth Trust (NCT)	Guideline	45	25	1.18.4 Does this need to refer to Social Services, and not just children's services?	Thank you for this comment. The suggested change has been made
National Childbirth Trust (NCT)	Guideline	47	16	1.19.3 We suggest you replace 'advise' with 'Discuss with the woman …'	Thank you for this comment. We considered the issue raised by you carefully and decided to use the verb "explain" rather than the original "advise" or your suggested "discuss" in this and several other recommendations
National Childbirth Trust (NCT)	Guideline	47	19	1.19.4 We suggest you replace 'advise' with 'Discuss with the woman …'	Thank you for this comment. We considered the issue raised by you carefully and decided to use the verb "explain" rather than the original "advise" or your suggested "discuss" in this and several other recommendations
National Childbirth Trust (NCT)	Guideline	47	22	1.19.5 We suggest replacing 'offering' with 'discussing'	Thank you for this comment. The change suggested by you has been made
National Childbirth Trust (NCT)	Guideline	47	6to7	1.19.1 We welcome this recommendation.	Thank you for this comment in support of the guideline
National Childbirth Trust (NCT)	Guideline	47	8	1.19.2 We suggest you replace 'advise' with 'Discuss with the woman …'	Thank you for this comment. We considered the issue raised by you carefully and decided to use the verb "explain" rather than the original "advise" or your suggested "discuss" in this and several other recommendations

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National Childbirth Trust (NCT)	Guideline	48	1 & 2	We suggest removing 'needing' and say 'reduces the chance of being offered a CS ' and 'increases the chance of being offered an operative birth'	Thank you for this comment. We have removed "needing" from this and a similar recommendation but the "chance" relates to actual mode of birth rather than the "offer"
National Childbirth Trust (NCT)	Guideline	48	21	1.20.1 "Offer continuous cardiotocography to women in labour after 42 weeks of pregnancy, explaining that there is an increased chance of stillbirth after 42 weeks". although there is no evidence to guide the choice of continuous cardiotocography compared with intermittent auscultation. It is unclear why this is a recommendation using 'offer' when it is clearly stated there is no evidence for it? We suggest saying "The GDG suggests you include this in discussion with the woman during the plan for birth made during pregnancy."	Thank you for this comment. We have discussed this and the recommendations have now been edited to state that continuous cardiotocography should be offered to all women in labour after 42 weeks of pregnancy after a full discussion of the benefits and risks to the woman and her baby. Although no evidence was identified for inclusion, the recommendation is in line with current practice. We agree with the provision of evidence-based information and discussion in the context of planning labour and birth; however, the scope of this guideline is intrapartum care, and therefore inclusion of discussion relevant to antenatal care is outside the scope of the guideline. The NICE guidelines on caesarean section (CG132) and antenatal care for uncomplicated pregnancies (CG62) cover the antenatal period
National Childbirth Trust (NCT)	Guideline	48	21	'Chance of stillbirth' does indeed increase but the incidence is small and there is wide variation, and the policy of 'personalised care' means women should be able to get an individual conversation discussing e.g. if she is a smoker (risk++), has a high BMI (risk+) or is relatively young, slim, healthy but has mum/sister/herself with history of long pregnancies (risk--). We suggest 1.20.1 might be re-worded as:	Thank you for this comment. We have discussed this and the recommendations have now been edited to state that continuous cardiotocography should be offered to all women in labour after 42 weeks of pregnancy after a full discussion of the benefits and risks to the woman and her baby. This recommendation is in line with current practice. The rationale and impact section explains that no

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				"There is no clear evidence on the benefits of use of continuous cardiotocography when a woman goes into labour after 42 weeks gestation. However, the GDG suggests that women discuss their individual situation with their caregivers and make a decision together regarding continuous monitoring."	evidence was found for monitoring in labour after 42 weeks of pregnancy and so the committee made recommendations based on their knowledge and experience. The reference to an increased chance of stillbirth has been deleted from the recommendations, however, the rationale and impact section mentions that we were aware of some evidence of an increased risk of stillbirth or neonatal death after 42 weeks and that this was consistent with our experience. The committee's discussion of the evidence section also mentions that we were aware of some evidence of an increased risk of intrapartum stillbirth or neonatal death after 42 weeks of pregnancy. This evidence was reviewed in the NICE guideline on inducing labour (CG70), which recommends induction between 41^{+0} and 42^{+0} weeks of pregnancy. The evidence is consistent with our experience. Page 28 of the full version of the NICE guideline on inducing labour (CG70) states that births after 42 weeks of pregnancy are associated with an increased risk of intrapartum and neonatal deaths. This evidence statement was based on non-analytical studies (for example, case reports or case series). We have discussed the reference that this comment makes to personalised care and agreed that the edits that we have now made to the recommendations support personalised care because women will be offered

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					continuous cardiotocography after a full discussion of the benefits and risks to the woman and her baby. The revised recommendation also states that if the woman declines continuous cardiotocography then her decision should be respected. A recommendation has also been added to the section on risk assessment for women with obstetric complications or no antenatal care, which recommends taking account of the whole clinical picture when discussing options for care with the woman during the intrapartum period
National Childbirth Trust (NCT)	Guideline	48	21	Overall the guidance here has a very negative tone: all about risks of poor outcomes. If the calculated risk of stillbirth is, e.g. 1 in 1000, then the woman could be advised that 999 out of 100 mothers in labour at 42 weeks have a healthy live baby.	Thank you for this comment. This recommendation has been simplified so that it no longer refers to the risk of stillbirth and neonatal death. Nevertheless it is the risk of stillbirth and neonatal death which underpins the recommendation and this is discussed in the rationale and impact section. No evidence was found for fetal and maternal monitoring for women in labour after 42 weeks of pregnancy. We were aware of some evidence of an increased risk of stillbirths and neonatal death after 42 weeks which mirrored our clinical experience. However, it was not possible to quantify the risk and therefore we considered that it was reasonable to refer to an "increased risk" in that context
National Childbirth Trust (NCT)	Guideline	48	6	We suggest replacing 'advise' with 'inform'	Thank you for this comment. In light of other stakeholder comments, the recommendations have been revised to

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					such an extent that the draft recommendation commented on by you has been deleted completely
National Childbirth Trust (NCT)	Guideline	49	1	1.20.2 If a woman in labour after 42 weeks of pregnancy declines continuous cardiotocography, offer intermittent auscultation in line with the NICE guideline on intrapartum care for healthy women and babies. We suggest: If a woman in labour after 42 weeks of pregnancy chooses intermittent auscultation over continuous cardiotocography, discuss with her the NICE guideline on intrapartum care for healthy women and babies.	Thank you for this comment. We have discussed this and the recommendations have now been edited to state that continuous cardiotocography should be offered to all women in labour after 42 weeks of pregnancy after a full discussion of the benefits and risks to the woman and her baby. The recommendation that the comment refers to has now been deleted. We agreed that the edits we have made to the recommendations support personalised care and women's choice because the offer of continuous cardiotocography will be preceded by a full discussion of the benefits and risks to the woman and her baby. Furthermore, the revised recommendation states that if the woman declines continuous cardiotocography then her decision should be respected
National Childbirth Trust (NCT)	Guideline	49	4	1.20.3 Explain to women in labour after 42 weeks of pregnancy that they have an increased risk of instrumental birth and caesarean section. We believe the term 'increased risk' when referring to 'instrumental birth and caesarean section' is not appropriate as instrumental birth and caesarean section are not things that happen to women on a 'risk' or 'chance' basis. They are medical procedures, which may or may not be offered/recommended to women according to a (hopefully evidence-based) decision process. We believe the	Thank you for this comment. We have now deleted this recommendation because it is beyond the scope of the review question. The review question was about maternal and fetal monitoring, as set out in the review protocol in appendix A of evidence review T. Although this recommendation has now been deleted, we wanted to mention in relation to the comment that studies often only report whether or not interventions have occurred, and what may be the official protocol, however studies would tend not to report in detail the discussions between women and healthcare professionals that

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				wording should reflect this – e.g. " … they may be more likely to be recommended an instrumental birth or caesarean section".	occurred before a decision was made to perform or not perform an intervention, so guideline recommendations only refer to an increased risk of receiving an intervention rather than to the likelihood of being recommended an intervention. In the consultation draft of evidence review T, in the committee's discussion of the evidence section, it was explained that this recommendation was based on the committee's knowledge and experience, as well as being informed by some descriptive data in the NICE guideline on inducing labour (CG70). Table 4.1 on page 25 of the full version of the inducing labour guideline reports descriptive data on maternal outcomes by week of pregnancy and is based on studies conducted in several different countries. The table shows a higher incidence of caesarean section and haemorrhage of more than 500 ml after 42 weeks of pregnancy compared to births at earlier gestational ages; these findings were based on a study conducted in Denmark. The table also shows a higher incidence of instrumental vaginal births at 42 weeks of pregnancy compared to births at earlier gestational ages; these findings were based on studies conducted in Norway, the USA and Israel. However, the inducing labour guideline does not provide an assessment of the statistical significance or clinical importance of the reported differences. This whole explanation has now

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					been deleted from the discussion of the evidence section, in line with the deletion of the recommendation
National Childbirth Trust (NCT)	Guideline	5	11	Suggest adding, "…before conception, if possible …	Thank you for this comment. We have added "if possible" to the recommendation
National Childbirth Trust (NCT)	Guideline	5	3	1.1.1: We welcome the recommendation of offering pregnant women, with an existing medical condition which may affect her or her baby during pregnancy or birth, information and the support of a multi-disciplinary team. However, we suggest the first bullet point should be: "evidence-based information where it exists'.	Thank you for this comment. We have added a reference to the NICE guideline on patient experience in adult NHS services (CG138), which outlines that information should be evidence-based ("give the patient (and their family members and/or carers if appropriate) clear, consistent, evidence-based, tailored information throughout all stages of their care", see recommendation 1.5.14 in CG138), therefore it was not considered necessary to add this here
National Childbirth Trust (NCT)	Guideline	7	12	1.3.3 It would be helpful to qualify 'low risk'. We presume this is low risk of complications which will affect the mother or her baby. It would be helpful to know here how the assessment of low risk is made – presumably the WHO 1 (Thorpe 2006) but it would help to be more explicit.	Thank you for this comment. To ensure clarity of what low-risk complications are we have added a reference to the modified WHO classification of risk. We do not wish to add specific examples or definitions within the recommendation itself, as recommendations should be succinct. For those with a specific interest in this recommendation they can refer not only to the reference, but to the rationale and impact section of the guideline
National Childbirth Trust (NCT)	Guideline	7	13	1.3.3. Rather than saying '…management should be in line with …' it would seem more appropriate to say '…care should be in line with…' reflecting shared decision making.	Thank you for this comment. We have amended the wording of the recommendation as suggested
National Childbirth Trust (NCT)	Guideline	7	22	Please report NYHA in full with abbreviation in brackets, as it is unclear to readers what this is and there appears to be no Glossary.	Thank you for this comment. We have added "New York Heart Association" in full, with the abbreviation in brackets as suggested

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				NYHA now found in Thorpe 2006 paper, but we feel it needs to be here in full with a reference.	
National Childbirth Trust (NCT)	Guideline	7	Footnote	It would help to reference a link to where this is explained further in the guideline – or in a publication. It is unclear what the 'Loeys Dietz syndrome' is.	Thank you for this comment. We have updated the reference in this section, which in turn has resulted in the specific reference to "Loeys Dietz syndrome" being deleted therefore, it would not be appropriate to define the syndrome here
National Childbirth Trust (NCT)	Guideline	8	1	1.3.5: It would be good to phrase this positively rather than negatively. So maybe: "Ensure that investigations are offered to pregnant women with heart disease and that the results are reviewed and acted upon without delay."	Thank you for this comment. We have amended the wording of the recommendation as suggested
National Childbirth Trust (NCT)	Guideline	8	21-	Similarly for the other recommendations for pregnant women with this medical condition.	Thank you for this comment. It is important that low-molecular weight heparin is stopped, and we do not think the recommendation is written in a negative way; therefore, we have decided to leave this recommendation as it stands
National Childbirth Trust (NCT)	Guideline	General	General	This has clearly been a difficult guideline to develop and we have found it hard to review as most of the recommendations are based on clinical opinion, as sound evidence is lacking. So it is hard for non-clinicians to assess the recommendations.	We appreciate that the guideline recommendations are largely based on clinical opinion although a robust process was used to search for and include any relevant evidence. We are grateful that you took the opportunity to comment
National Childbirth Trust (NCT)	Guideline	General	General	We believe that throughout the guideline, women's preferences should come ahead of Obstetric indications. This puts the woman as decision maker and recognises chronology and Obstetric indications coming late.	Thank you for this comment. This guideline is focused on intrapartum care and therefore we can only make recommendations that relate to labour and birth. We have considered the ordering of phrases in specific recommendations and where appropriate reworded to

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				We believe that it is really important to recommend that women discuss the various possible scenarios they might face during labour with the multi-disciplinary team during pregnancy. There should be a 'Plan for labour' (as labour may occur prematurely), a plan for induction (if clinically appropriate), interventions during labour including emergency CS, elective CS and then implications of the condition and treatments for the immediate postnatal period, eg effects of analgesia or drug regimes on breastfeeding.	emphasise the importance of the woman as the decision maker regarding her care and of taking account of her preferences and wishes
National Childbirth Trust (NCT)	Guideline	General	General	Any recommendations in the guideline should progress from less invasive to more invasive e.g. IOL ahead of CS.	Thank you for this comment. We have re-examined the wording of recommendations and revised the ordering of phrases in line with the principle that interventions should progress from less invasive to more invasive
National Childbirth Trust (NCT)	Guideline	General	General	NCT has always regretted that NICE dropped reporting the grading of their recommendations – as nearly all the recommendations in this guideline would be 'Good Practice Points' (GPP). As the grading of the recommendations has not been re-introduced we suggest that, as well as the statement at the beginning of each section, using particular wording to clarify whether the recommendation is based on research evidence or clinical expertise. So perhaps: The GDG recommends….' when there is research evidence, and 'The GDG suggests…' when it is the clinical opinion of the members of the GDG. Whilst it is stated that the GDG uses wording to reflect the evidence base, this appears not to have been adhered to very closely. e.g. 1.3.7 above – the current wording is "…switch to…" which is very	Thank you for this comment. Although each recommendation is not specifically graded, all included outcomes are graded as either high, moderate, low or very low quality, thereby ensuring transparency of the considerations regarding quality of evidence upon which the recommendations are based. In addition, the rationale and impact sections which relate to each group of recommendations discuss the quality of evidence and how the recommendations were made, including whether this was on available evidence, informal consensus or a combination of the two. Therefore we do not think it is necessary to reword each recommendation stating whether it based on consensus or evidence.

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				direct and without qualification yet appears to be without an evidence base. Once decided upon, this wording should be included in a list of terms and abbreviations/ glossary.	You acknowledge that recommendations are written using wording to reflect the evidence base. The particular example given of "switch to" relates to women with mechanical heart failure and the use of anticoagulation. Although the phrase "switch to" is used, the recommendation then goes on to use the word "consider", providing a range of options, and as such we do not agree this is a strong recommendation which needs changing. We do not agree this wording needs changing, and therefore have not added them to the list of abbreviations as suggested
National Childbirth Trust (NCT)	Guideline	General	Title	We welcome the change of title from '…high-risk women…' to '…women with existing medical conditions…'	Thank you for this comment in support of the guideline
National Childbirth Trust (NCT)	Guideline	General and 8	General 9	We are concerned that readers may take away the impression that these recommendations are based on research evidence, which is sadly lacking. We suggest a clear statement at the beginning of each section or within each recommendation, regarding the lack of research evidence meaning that the recommendations are based on clinical expertise. We acknowledge that this information is there if one follows the link, but recommendations are often all that people read. For example: 1.3.7 For women with mechanical heart valves who are taking warfarin in the third trimester, the GDG suggests switching	Thank you for this comment. As you acknowledge, how the recommendations have been developed, either according to available evidence or by informal consensus, is clearly documented in the rationale and impact sections of the guideline. In addition, there is a whole section regarding quality of the evidence within each section on the committee's discussion of the evidence which goes into detail as to why the evidence was graded as either high, moderate, low or very low quality. Furthermore, where evidence is lacking, the recommendations are worded to reflect this, generally using a "consider" recommendation to demonstrate uncertainty. It is not

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				anticoagulation to low-molecular-weight heparin by 36+0 weeks of pregnancy or 2 weeks before planned birth (if this is earlier than 36+0 weeks) (although research evidence is lacking). Consider doing this by: ……"	possible within each recommendation to additionally discuss the evidence on which it is based
National Maternity Voices	General	General	General	National Maternity Voices is the national network of Maternity Voices Partnerships in England (see NHS England Maternity Transformation Implementation Resource Pack, Chapter 4 Co-production and Annex B). This response is submitted on behalf of the acting committee of National Maternity Voices, representing the service user chairs of Maternity Voices Partnerships and their service user members. We are pleased to see this draft guideline published, recognising the care needs of a diverse range of women, and recommending new research where there is limited or no evidence of suitable quality on which to base recommendations currently. Our focus in this consultation response is on enhancing the woman-centredness of the draft recommendations – and this includes asking the NICE committees to look again at how they have covered information-giving. Our view is that many of the recommendations need to be strengthened to recognise the woman as an informed decision-maker in her own life and care.	Thank you for this comment. We have re-examined the wording of recommendations in the light of comments received about language and made a number of revisions in order to give greater recognition to the woman as an informed decision-maker regarding her care
National Maternity Voices	Guideline	10	20	1.3.17 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. The recommendation has been reworded to ensure it is clear that the woman is involved in developing her emergency birth plan
National Maternity Voices	Guideline	10	4	1.3.14 National Maternity Voices suggests that the woman should be involved in developing her care plan. Please say so – it is her care plan – about caring for her.	Thank you for this comment. The recommendation has been amended to ensure it is clear that the woman is involved in developing her care plan

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National Maternity Voices	Guideline	14	6	1.3.32 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We have amended the recommendation to include the term "and the woman" to ensure it is clear that the woman is involved in developing her care plan
National Maternity Voices	Guideline	15	10	1.3.40 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We have amended the recommendation to include the term "and the woman" to ensure it is clear that the woman is involved in developing her care plan
National Maternity Voices	Guideline	23	2	1.7.3 National Maternity Voices– again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We believe that the woman should be involved and indeed at the centre of planning of her care. We have amended the wording to make this clear and we think this is reflected in the recommendation now as it says to base the decision on the mode of birth on the woman's preference (and obstetric indications)
National Maternity Voices	Guideline	26	17	1.8.11 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We have amended the wording of the recommendation to emphasise that the woman should be included in her intrapartum care planning
National Maternity Voices	Guideline	26	22-23	1.8.12 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We believe that the woman should be involved and indeed at the centre of planning of her care. We think this is reflected in the recommendations and we have amended the wording to emphasise this
National Maternity Voices	Guideline	27	14-15	1.8.16 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We believe that the woman should be involved and indeed at the centre of planning of her care. We think this is reflected in the

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					recommendations and we have amended the wording to emphasise this
National Maternity Voices	Guideline	27 onwards		National Maternity Voices is aware that in many services women with a raised BMI are using Alongside Midwifery Units. These draft recommendations seem to think this does not happen? There is Birthplace evidence about outcomes for women who have a high BMI and are otherwise healthy, but you have not referred to it? https://www.rcog.org.uk/en/news/bjog-release-low-risk-obese-women-who-have-previously-given-birth-may-have-fewer-complications-than-previously-thought/ Have you looked at anything published by NPEU/UkmidSS? https://www.npeu.ox.ac.uk/ukmidss/news/1538-ukmidss-severe-obesity-study-results-presented-at-bmfms-20th-annual-conference Sensible and individual risk assessment and care planning is essential, but we are concerned that the effect of the recommendations may be to limit women's appropriate access to AMUs when they have a raised BMI but are otherwise well.	Thank you for this comment. Place of birth was outside the scope of this guideline and no recommendations were made on the place of birth. The scope of this section focused on specific topics (see evidence review I for details) and the referenced publications are not relevant to these. in addition conference abstracts were not considered for inclusion as they do not contain sufficient information to fully review and appraise the associated studies. We are aware that many women with raised BMIs give birth in alongside midwifery units and the recommendations do not discourage this
National Maternity Voices	Guideline	28	14-15	1.9.4 National Maternity Voices is surprised to see a recommendation about position in the second stage of labour for women with high BMI as there was no evidence to review – isn't this a discussion between the particular woman and her midwife on the day? Why would NICE suggesting a lying-down position, without evidence and without being there to assess the situation, be a good idea? Isn't this a conversation between the women and her midwife at the time?	Thank you for this comment. This recommendation is for women with a BMI over 30 at the booking appointment and reduced mobility during the third trimester. Unfortunately the consultation version of the document had an omission of "with reduced mobility". We have now corrected this wording. There was no clinical evidence identified and the recommendation was based on the committee's experience. The committee balanced the benefits and risks of finding a comfortable position for the woman with reduced mobility in the second stage of

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					labour to the benefits and risks of adequate access for healthcare professionals in case of a high-risk but low-probability emergency. In the committee's discussion of the evidence section in evidence review I we write: "Based on their experience, the committee discussed how a left-lateral position was sometimes helpful for women with reduced mobility. They discussed how this position was usually comfortable for the woman, but at the same time allowed healthcare professionals to have access to the woman, for example, to provide peritoneal support. The committee agreed that in the event of an obstetric emergency such access would be potentially life-saving, but the left-lateral position was not the only position which would allow access in this way; however, it was likely that healthcare professionals (and especially midwives) would be most familiar with the position. Based on their experience, the committee determined that management only needed to change from recommendations in the NICE guideline on intrapartum care for healthy women and babies (CG190) if the woman's mobility was affected by her obesity. Consequently the committee determined that in women with a BMI over 30 kg/m^2 and adequate mobility there was no reason to manage labour and birth differently from the recommendations in the existing guideline." The previous recommendation outlines that assessment of the woman's mobility and birth plan should be done together with the woman during the third trimester. In practice this discussion will probably continue

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					during labour but we found it important that these considerations are discussed with the woman before labour and birth. The position in which the woman chooses to give birth ultimately depends on the woman's preference but we think that it is important that these considerations are discussed with the woman
National Maternity Voices	Guideline	28	17	1.9.5 National Maternity Voices thinks that a woman 'receives care in pregnancy and birth' rather than 'being managed'– how midwives and doctors speak/think about women really matters in our experience. Human language makes for human care. Please say 'provide care in the second stage'	Thank you for this comment. We agree and have made the change suggested
National Maternity Voices	Guideline	28	9	1.9.3 National Maternity Voices – again, isn't the woman someone who needs to be mentioned as involved in developing the care plan?	Thank you for this comment. We have added "with the woman" to the recommendation to emphasise the importance of involving the woman in the planning of her care
National Maternity Voices	Guideline	29	13-15	1.9.8 National Maternity Voices would like to see reference here to training staff to ensure that appropriate and sensitive language is used when talking with women about their BMI. Many feel judged, and this might affect how willing they are to engage with services.	Thank you for this comment. We agree that the language used may have a significant effect on the experience of the woman and we think that sensitive, respectful and professional language should always be used by people caring for the woman, however, this was not in the scope of this guideline and is set out in the NICE guideline on patient experience in adult NHS services (CG138), which we have added a reference to in the information for women with existing medical conditions section
National Maternity Voices	Guideline	29	2to3	1.9.6 National Maternity Voices notes that there is no recognition here that there are women with high BMI birthing safely in AMUs – without special beds. Services looking at this recommendation may	Thank you for this comment. Place of birth is outside the scope of this guideline. We are aware that many women with raised BMI give birth in alongside midwifery units and

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				think they either need to kit out AMUs with Obstetric furniture, or that there is some kind of evidence that no women at all with raised BMI should birth in AMUs, despite the evidence there is about safety for some women. We suggest adding a sentence to say, 'Obstetric Unit(s) and Midwifery Units in maternity networks should liaise so that each part of the service knows which setting has which types of equipment available or unavailable.'	also that some alongside midwifery units have acquired equipment that is appropriate for women with raised BMIs as the population with obesity has increased. It is a matter for local implementation for alongside midwifery units and obstetric units to communicate and liaise with each other about their limits and equipment, therefore, no recommendation on this was made
National Maternity Voices	Guideline	30	1to13	1.10.2-1.10.5 National Maternity Voices welcomes these recommendations. We would like to see (a) a cross reference to guideline 138 about evidence-based information-giving (if you don't include it and spell out what the relevant sections say, what happens in service will not change – in service there is too much 'what we do here' or 'what we recommend is' and not enough here are the options, the Benefits Risks Alternatives and figures on a decision aid, if you want them. (b)an amendment because assuming at 1.10.5 that the birth companion(s) are entitled to information is wrong – the guidelines need to say 'the woman and (if she wishes and consents) her birth companion(s)…'	Thank you for this comment. The recommendations have been amended to refer to presenting information in line with the NICE guideline on patient experience in adult NHS services (CG138). The specific forms of presentation suggested by you have not been included in the recommendations because these are referenced in the patient experience guideline. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's

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					birth companions and this is why the over-arching recommendations have been added
National Maternity Voices	Guideline	36	11	1.13.9 National Maternity Voices is concerned that the wording here makes it sound as though the doctor decides what will happen – surely the Obstetrician 'advises' or makes a recommendation' about timing and mode of birth. Guidance and training on recommending rather than 'telling' is now taken up by many trusts from the human rights charity Birthrights – there is widespread recognition that a paternalistic approach in conversations with women using maternity services is not acceptable, intentionally or otherwise.	Thank you for this comment. The wording has been amended to refer to "discussing" with the woman rather than the possibility of "deciding" on her behalf
National Maternity Voices	Guideline	36	4	1.13.8 National Maternity Voices is pleased to see the reference to shared decision-making but there is no right for birth companion(s) to be involve and this must be clear – better to say 'and (if the woman wishes and consents) her birth companion(s)'	Thank you for this comment. The recommendations have been amended to refer to presenting information in line with the NICE guideline on patient experience in adult NHS services (CG138). The specific forms of presentation suggested by you have not been included in the recommendations because these are referenced in the patient experience guideline. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line

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					with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
National Maternity Voices	Guideline	38	13	1.13.20 National Maternity Voices – here we suggest it should read 'explain to the woman (and if she wishes and consents) to her birth companion(s)' -again because the support of any life partner or other companion is likely to be valuable to the woman, but it should not be assumed or suggested that the other person has a right to be involved in decision-making by the woman.	Thank you for this comment. The recommendations have been amended to refer to presenting information in line with the NICE guideline on patient experience in adult NHS services (CG138). The specific forms of presentation suggested by you have not been included in the recommendations because these are referenced in the patient experience guideline. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added

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National Maternity Voices	Guideline	41	1to3	1.14.5 National Maternity Voices would strongly prefer 'agree and document a care plan with the woman, with multidisciplinary involvement, including etc'. The tone of the recommendation is unfortunately paternalistic – under the NHS constitution the woman has a right to be involved in planning her own care, additional to her right to accept or decline anything that is simply 'put' to her for decision.	Thank you for this comment. We have altered the wording as suggested
National Maternity Voices	Guideline	42	14-18	1.15.2-3 National Maternity Voices would again like to see the NICE standard for sharing and presenting information/absolute figures in an unbiased way made clear.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
National Maternity Voices	Guideline	42	6to13	1.15 National Maternity Voices is concerned (based on past experience of interviewing women in services, and conversations with midwives and doctors services) that the wording of this recommendation will be treated as 'the standard' unless you spell to	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the

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				that women are entitled to know the probabilities (absolute figures) and that there is a NICE standard for giving numerical information (in guideline 138 referred to above). It would be best to include the figures in a suitable format, if possible – as in Tables 2 and 4 in guideline 190 (Intrapartum Care 1)	evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
National Maternity Voices	Guideline	44	5to15	1.17.2 National Maternity Voices would again like to see the NICE standard for sharing and presenting information/absolute figures in an unbiased way made clear. Again, explain to the birth companion(s) '(if she wishes and consents)'.	Thank you for this comment. The recommendations have been amended to refer to presenting information in line with the NICE guideline on patient experience in adult NHS services (CG138). The specific forms of presentation suggested by you have not been included in the recommendations because these are referenced in the patient experience guideline. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These

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					recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
National Maternity Voices	Guideline	47, 48	8-24 & 1-9	1.19.2-4, 1.19.7 National Maternity Voices would again like to see the NICE standard for sharing and presenting information/absolute figures in an unbiased way made clear.	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
National Maternity Voices	Guideline	48	22	1.20.1 National Maternity Voices is aware that women are often offered induction 'for dates' without a full and unbiased discussion, and that there is often a vague and scary reference to 'an increased risk of stillbirth', without information to allow the woman to make her	Thank you for this comment. We agree with the principles outlined by you in terms of presenting information about benefits and risks in ways that women can readily understand and interpret. However, not only was the

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				own mind up. National Maternity Voices would again like to see the NICE standard for sharing and presenting information/absolute figures in an unbiased way made clear. Could NICE include a two-way table like those used in the first section of guideline 190 (Intrapartum Care 1)? The absolute risks are small, and how each woman feels about the increase in risk is a matter for her to decide on.	evidence identified for inclusion of very low quality, it was also sparse in the sense that it indicated some benefits and risks of the interventions considered but without allowing detailed figures to be presented in the format suggested by you. We discussed whether or not to include some figures in the recommendations, and ultimately agreed that unless all the risks could be quantified in the ways suggested by you it was preferable not to insert any figures in the recommendations themselves, but to retain the qualitative statements about outcomes that would tend to occur more or less often with certain interventions
National Maternity Voices	Guideline	5	10to 12	National Maternity Voices gets feedback from member partnerships that women report time with midwives, and sometimes with Obstetricians too, feeling rushed. Good to see that the need for proper conversations is covered here.	Thank you for this comment in support of the guideline
National Maternity Voices	Guideline	5	12	1.3.3 National Maternity Voices suggests be plain that you mean 'at low risk of complications'	Thank you for this comment. We have amended the wording of the recommendation as suggested
National Maternity Voices	Guideline	5	13	1.3.3 National Maternity Voices has a strong preference for services 'providing care' to women rather than 'managing' them – again, how we speak about people can affect how we treat them – this does matter.	Thank you for this comment. We have amended the wording of the recommendations as suggested
National Maternity Voices	Guideline	5	18	1.1.4 National Maternity Voices thinks that a woman 'receives care in pregnancy' rather than 'presenting' – how midwives and doctors speak/think about women really matters in our experience. Human language makes for human care.	Thank you for this comment. We have amended the wording of the recommendation and we no longer use the word "presenting"

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National Maternity Voices	Guideline	5	3	National Maternity Voices is pleased that this recommendation recognises that anyone accompanying a woman in her pregnancy and birth journey is a 'companion' who does not make the decisions for her. Partners (fathers and others) matter very much, and women often freely invite them into decision-making – but some partners are controlling, some are physically abusive, and some women don't have a partner. It is so important that NICE gives a lead in reminding everyone that the woman is the person who decides about her own body in pregnancy, labour and birth, and that 'mother and baby are one.'	Thank you for this comment in support of the guideline. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
National Maternity Voices	Guideline	5	3to9	National Maternity Voices encourages NICE to make good use of its own recommendations on 'patient experience in NHS services' (guideline no. 138) – section 1.5 including recommendations on information-giving is particularly important.	Thank you for this comment. We have added a reference to the NICE guideline on patient experience in adult NHS services (CG138) in various parts of the guideline, recognising the importance of the issues raised by you and in CG138
National Maternity Voices	Guideline	5	9to11	1.2.1 National Maternity Voices is really concerned at the implication that birth companions have a right to information. Often the woman wants to include her partner/family but this must never be assumed. There is a duty of confidentiality – and surely an Equalities duty here to, to promote women's awareness of their rights and autonomy, as sadly, not all know or can exercise their rights.	Thank you for this comment. We agree that women's birth companions should only be involved in the shared decision-making if the woman consents to it. We have added new recommendations about this. The references to sharing information with the woman's birth companion(s), and involving them in discussions about care, are now preceded by recommendations to clarify

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					with women with existing medical conditions, obstetric complications or no antenatal care whether and how they would like their birth companion(s) involved in discussions about care during labour and birth. These recommendations further state that this should be reviewed regularly. The new recommendations are in line with the NICE guideline on patient experience in adult NHS services (CG138). It was not considered feasible to add this to every recommendation that refers to women's birth companions and this is why the over-arching recommendations have been added
National Maternity Voices	Guideline	8	5	1.3.8-1.3.13 National Maternity Voices queries: from a woman-centred perspective, thinking about the woman's journey and care plan, not sure these recommendations are in the right order? May need reviewing.	Thank you for this comment. The recommendations in this section have been re-ordered and re-structured in what we agree is a woman-centred perspective
National Maternity Voices	Guideline	91	1to24	National Maternity Voices wishes to draw to the attention of the NICE committees sections 3.2 and 3.3 on page 31 of the Better Births report – '*[Women] resented the implications of their care being labelled high, medium or low risk'*. The recommendations of the report emphasise the need for personalised care planning. Given the range of different conditions covered in this draft guideline (which is by no means exhaustive) is the generic label 'high risk' for a pregnancy and/or birth meaningful or useful? Doesn't the long title of the guideline impart more accurate and helpful information? Jargon can affect culture – so please only use it if confers a real and important benefit to women in clinic and birth settings.	Thank you for this comment. We have amended the text in this section to emphasise the importance of individualised care in risk assessment and planning. This section defines "high risk" as a risk higher than in the "normal population" and is intended to distinguish the population in this guideline from the population of "healthy women and babies" in the NICE guideline on intrapartum care for healthy women and babies (CG190). Whilst recognising your concerns we think this is appropriate in this context as the population covered by the guideline often requires care over and above that recommended in CG190. However, a number of recommendations also

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					recognise that individualised care and risk assessment mean that it will be appropriate for some women to be cared for as per the recommendations in CG190
Obstetric Anaesthetists' Association	Guideline	11	19	Surprised no comment here about use or not of CVP.	Thank you for this comment. We do not want to directly recommend the use of central venous pressure. However, we acknowledge that some practitioners use it and do not, therefore, want to explicitly say they cannot. Central venous pressure does not predict fluid responsiveness and as such, it is not included in the recommendation
Obstetric Anaesthetists' Association	Guideline	14	16	Section 1.3.36: It is unclear exactly what is meant by "low-dose spinal". This could be interpreted in different ways by different clinicians.	Thank you for this comment. We have amended the rationale and impact section of the guideline to state that 'low-dose spinal' refers to sequential combined spinal epidural or carefully titrated continuous spinal catheter techniques
Obstetric Anaesthetists' Association	Guideline	14	20	Section 1.3.37: The expression "Offer close monitoring…" is too vague to be of use.	Thank you for this comment. We have amended the recommendation by adding the word "intrapartum" to clarify when this monitoring should take place
Obstetric Anaesthetists' Association	Guideline	15	1	Section 1.3.38: The expression "Offer cardio-stable low-dose regional analgesia…" is similarly unhelpful. No analgesia should be cardio-unstable. It would be better to state that low dose neuraxial analgesia should be offered as this is less likely to produce cardiovascular instability.	Thank you for this comment. We agree that no analgesia should be cardio-unstable and so we have amended the wording of the recommendation to refer to low-dose regional analgesia instead
Obstetric Anaesthetists' Association	Guideline	17	6	Section 1.4.1: The term "epidurals" is perhaps a little colloquial. It would be better to group "epidural and combined spinal-epidural analgesia" together as one bullet point.	Thank you for this comment. We have amended the wording of this recommendation to the single form "epidural", however, we have left the options as two bullets as the woman may receive either option

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Obstetric Anaesthetists' Association	Guideline	19	1	Section 1.6: The lack of references makes this section somewhat controversial. Epidural haematoma is fortunately a rare complication of neuraxial blockade but may become more common if a more liberal approach to block insertion in the presence of thrombocytopenia is adopted. Although there may be no evidence of harm at platelet counts of 50 x 109/L this does not imply relative safely. It may simply reflect that very few blocks are performed when the platelet count falls below 75 x 109/L. Impairment of clot strength measured by thromboelastography has been noted when platelet counts fall below 75 x 109/L. Consequently extreme caution should be exercised before a block is performed below this level. The message in the draft guideline may lead to inappropriate attempts to site neuraxial blocks in women at increased risk of bleeding complications. Finally, there is no mention of checking coagulation parameters before removing an epidural catheter	Thank you for this comment. We agree that caution should be exercised before performing a block with platelet counts between 50 to 80 × 10^9/litre and we have amended table 2 so that the importance of taking into account clinical history and women's preferences prior to regional analgesia or anaesthesia has been emphasised. There is no evidence to guide clinicians on the level of platelet count at which it is safe to remove an epidural catheter. If there was no bleeding on needle insertion, we thought it unlikely that epidural catheter removal would initiate new bleeding. We have therefore avoided making a recommendation on epidural catheter removal, but we do now reflect this clinical opinion in the committee's discussion of the evidence section in evidence review F
Obstetric Anaesthetists' Association	Guideline	19	1	Section 1.6: The document only refers to absolute numbers of platelets rather than rate of decay. Although significant deterioration is more commonly associated with thrombocytopenia in pre-eclampsia, it should not be overlooked in other conditions.	Thank you for this comment. The point made by you is reasonable but there is no mechanism of measuring the rate of decay other than by serial platelet counts. Recommendation 1.6.3 states "consider monitoring maternal platelet count weekly from 36 weeks, and if the platelet count is below 50". In table 2, we refer to absolute platelet counts at the moment a decision for giving or withholding regional anaesthesia or analgesia is made
Obstetric Anaesthetists' Association	Guideline	27	18	Section 1.9: There is no recommendation on the BMI at which the anaesthetist should be directly involved in intrapartum care.	Thank you for this comment. This is a good point, however, as the guideline covers intrapartum care for women with medical conditions or obstetric complications the section on obesity had to be kept focused on specific

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					clinical areas that were prioritised as part of the guideline scoping process. As we did not review the evidence we were not able to make a recommendation on the BMI cut-off at which an anaesthetist should be directly involved in intrapartum care. However, we did discuss this and considered that normally an anaesthetist should be made aware if a woman with a BMI over 40 is admitted for birth. This is noted in the rationale and impact section
Obstetric Anaesthetists' Association	Guideline	36	23	Section 1.13.11: Epidural abscess is uncommon. In the presence of overt sepsis with organ dysfunction (as defined in 1.13.6), most anaesthetists would consider it unwise to perform a neuraxial block. The relative lack of cases of infectious complications is not sufficient evidence to suggest blocks should be considered. It more likely reflects that blocks are rarely performed in septic patients with organ dysfunction.	Thank you for this comment. We have discussed this and agreed that the lack of evidence of adverse outcomes should not be interpreted as evidence of safety of regional anaesthesia for women in labour with sepsis and signs of organ dysfunction. As stated in the rationale and impact section, in the absence of evidence the committee made recommendations based on their expertise and knowledge of good practice. They wanted to ensure that these women would be offered anaesthesia appropriate to their clinical condition and noted that the default practice of using regional anaesthesia may not be appropriate for these women. The recommendation has now been edited to say that for women in labour with sepsis and signs of organ dysfunction, regional anaesthesia should only be used with caution and advice from a consultant obstetric anaesthetist, and with a senior anaesthetist present. We have also added the following to the committee's discussion of the evidence section: "The committee felt that if antibiotics had been given and the woman's

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					condition was improving, regional anaesthesia might be considered. If an epidural catheter had already been placed, the continued use of this may be appropriate." In relation to the reference to epidural abscess in this comment, the rationale and impact section does not comment on the frequency of this complication and only states that regional anaesthesia may be associated with cardiovascular instability when there is sepsis with signs of organ dysfunction, and other adverse outcomes may include epidural abscess and haematoma due to coagulopathy. Moreover, the committee's discussion of the evidence section mentions that for women in labour with sepsis and signs of organ dysfunction there is a higher risk of coagulopathy, which is a contraindication to neuraxial blockade and there is a theoretical risk of causing an epidural abscess or haematoma because, if the woman is coagulopathic, the insertion or attempted insertion might cause bleeding within the epidural space
Obstetric Anaesthetists' Association	Guideline	36	23	Section 1.13: If a consultant anaesthetist needs to be present for anaesthesia in the presence of sepsis and organ dysfunction (section 1.13.11) should the guidelines not state that a consultant Obstetrician should also be present?	Thank you for this comment. The first recommendation in this section on anaesthesia and analgesia for women in labour with sepsis or suspected sepsis has now been edited to state that for women in labour with sepsis and signs of organ dysfunction, regional anaesthesia should only be used with caution and advice from a consultant obstetric anaesthetist, and with a senior anaesthetist present. We have discussed this comment and agreed

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					that recommendations in this section are specifically about anaesthesia and analgesia so the input of obstetric expertise does not need specific mention
Obstetric Anaesthetists' Association	Guideline	36	23 onwards	This is set of recommendations is not well written. 1.13.11 and 1.13.13 seem to be repeated but not sure whether you want presence or advice of consultant Obstetric anaesthetist. 1.13.12 is it ok to use regional analgesia in these? I think so but should be more explicit. 1.13.14 so the assumption here is that regional analgesia is ok? Even if there are systemic signs of infection? please clarify.	Thank you for this comment. One recommendation refers to regional anaesthesia and the other refers to regional analgesia. Regional anaesthesia is different from regional analgesia because the former is used before surgery and so requires a stronger dose of local anaesthetic. These recommendations have now been edited. One recommendation now states that for women in labour with sepsis and signs of organ dysfunction, regional anaesthesia should only be used with caution and advice from a consultant obstetric anaesthetist, and with a senior anaesthetist present. The other recommendation now states that for women in labour with sepsis and signs of organ dysfunction, regional analgesia should only be used with caution and advice from a consultant obstetric anaesthetist. The rationale and impact section explains that the presence of a senior anaesthetist is not needed with regional analgesia because of the lower dose of local anaesthetic used for a woman who is not having surgery
Obstetric Anaesthetists' Association	Guideline	36 & 37	23 &4	Recommendations 1.13.11 and 1.13.13 are almost exactly the same	Thank you for this comment. One recommendation refers to regional anaesthesia and the other refers to regional analgesia. Regional anaesthesia is different from regional analgesia because the former is used before surgery and so requires a stronger dose of local anaesthetic. These recommendations have now been edited. One

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					recommendation now states that for women in labour with sepsis and signs of organ dysfunction, regional anaesthesia should only be used with caution and advice from a consultant obstetric anaesthetist, and with a senior anaesthetist present. The other recommendation now states that for women in labour with sepsis and signs of organ dysfunction, regional analgesia should only be used with caution and advice from a consultant obstetric anaesthetist. The rationale and impact section explains that the presence of a senior anaesthetist is not needed with regional analgesia because of the lower dose of local anaesthetic used for a woman who is not having surgery
Obstetric Anaesthetists' Association	Guideline	49	18	Should be "epidural" not "epidurals".	Thank you for this comment. The typographical error has been corrected
Obstetric Anaesthetists' Association	Guideline	57	24	Should be "analgesia" not "anaesthesia".	Thank you for this comment. We have corrected the wording to "analgesia".
Obstetric Anaesthetists' Association	Guideline	7	Section 1.3	The section on anticoagulation considers warfarin, unfractionated heparin and low molecular weight heparin. The use of other newer anticoagulants is not considered. Although their use is not currently widespread, some acknowledgement of their existence should be made.	Thank you for this comment. As you state, newer anticoagulants are not widely used in clinical practice; therefore, we do not feel we should make specific recommendations on their use. We do agree that there should be some acknowledgment of their existence and have added an additional statement to the rationale and impact section to explain this

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Obstetric Anaesthetists' Association	Guideline	General	General	The draft guidelines contain no references. It is therefore difficult to know the basis on which some recommendations have been made.	Thank you for this comment. References underpinning each evidence review are contained within each evidence review, and we refer you to the last page of the main part of each relevant document (before the associated appendices) where these are located
Obstetric Anaesthetists' Association	Guideline	General	General	The document uses the term "regional" to describe epidural, spinal and combined spinal-epidural blocks. The more modern terminology is "neuraxial".	Thank you for this comment. The term 'regional' anaesthesia and analgesia is used in the NICE guideline on intrapartum care for healthy women and babies (CG190). We have used the same terminology here for consistency and because we know that women read NICE guidelines and 'regional' is a lay friendly term that they are familiar with. We have also defined regional anaesthesia and analgesia in the section headed terms used in this guideline (this states that regional anaesthesia and analgesia include spinal, epidural and combined spinal–epidural techniques)
Obstetric Anaesthetists' Association	Guideline	General	General	The terms "consultant" and "senior" are both used in the document. The word "senior" should be more clearly defined.	Thank you for this comment. The terms "senior" and "consultant" are both used in the guideline as they would be in clinical practice. "Senior" refers to a clinician with expertise in providing care in particular circumstances, whether they be a consultant or a senior registrar with specialist training in the relevant clinical area. Where there is a specific requirement to involve a consultant in the woman's or baby's care this is specified in the recommendations. The term "senior" typically refers to a clinician with at least 5 years' specialty training

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Obstetric Anaesthetists' Association	Guideline	General	General	A number of recommendations are based on opinion rather than scientific evidence. Some of the views expressed are somewhat controversial; examples included platelet counts and sepsis.	Thank you for this comment. The generalities of formulating recommendations when there is a lack of evidence are addressed in responses to various stakeholder comments on the draft guideline and they include having conducted a search for evidence and documenting the committee's discussion when there is no available evidence. The specific comments contributed by you, including those relating to platelet counts and sepsis, have been considered by the relevant guideline committee. For example, the concerns relating to platelet counts where the "lack of references makes this section somewhat controversial" are addressed in the response to that specific comment. Similarly, the concerns relating to sepsis and the possibility of an epidural abscess not being associated with "sufficient evidence to suggest blocks" is addressed in the response to that specific comment
RCGP	General	General	General	Not really relevant to GPs	Thank you for this comment
RCGP	General	General	General	Could maybe emphasise the need for specialist pre-conception care for most women this guideline will include, not just starting early in pregnancy	Thank you for this comment. We think this is emphasised as we recommend: 1.1.2 Offer information about intrapartum care in consultations prior to conception, if possible, and as early as possible during pregnancy. Allow extra time to discuss with the woman how her medical condition may affect her care
RCGP	General	General	General	Most women will not have just one condition, they may have several. What will happen then? Clearly women don't want 2 leads for their separate conditions.	Thank you for this comment. We recognise that women can have comorbidities but we believe it is still important to have a single named healthcare professional as the

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					lead for the multidisciplinary team, although this does not preclude the involvement of other specialties relevant to the woman's care
RCGP	General	General	General	Diabetes and hypertension are not included because they have separate guidelines, but they are going to be the co-morbidities that are most common. There should be a reminder of that somewhere	Thank you for this comment. When the guideline is published the recommendations will be added to a new NICE pathway, which will be accessible from the existing pathway for intrapartum care. The new pathway will link to existing pathways that cover intrapartum care that are outside the scope of this guideline, including diabetes in pregnancy and hypertension in pregnancy. NICE pathways bring together all related NICE guidance and associated products on a topic in an interactive web-based topic-based flow chart. In addition, recommendation 1.8.4 notes that renal impairment secondary to pre-eclampsia should be managed in line with the NICE guideline on hypertension in pregnancy (CG107). Also, the NICE guideline on diabetes in pregnancy (NG3) is signposted at the end of the recommendations about information for women with existing medical conditions
RCGP	General	General	General	At no time are mental health disorders considered in this document and women with serious medical conditions are more likely to have these during labour and they are worth a mention	Thank you for this comment. The guideline scope explicitly excludes women with mental health conditions (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2) and states that NICE will consider how best to address this in the future. The rationale for this decision was that this is considered

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					a large topic in its own right which is pertinent to all births, not just those with a higher risk of adverse outcomes. The scope does note that the NICE guideline on antenatal and postnatal mental health (CG192) provides related guidance
RCGP	Guideline	12	20	There are other conditions to exclude as well, even if the woman has heart disease e.g. PE, bleeding, sepsis	Thank you for this comment. The signs included in the list are those that should raise suspicion of heart failure in the intrapartum period, which should prompt a consultant review, as specified in the following recommendation, and this review will determine whether or not other conditions can be excluded
RCGP	Guideline	17	5	Were NSAIDs considered? If they are safe maybe a specific point would be worth making	Thank you for this comment. Nonsteroidal anti-inflammatory drugs (NSAIDs) are not recommended for pregnant women after 30-32 weeks of pregnancy and so they were not considered relevant for treating pain during labour
RCGP	Guideline	29	1	Should this be women with BMI> 40?	Thank you for this comment. This section covers women with BMI over 30 as this is the internationally recognised cut-off for obesity
RCGP	Guideline	50	7	The title isn't clear if this is about women or infants	Thank you for this comment. We have added "perinatal mortality and morbidity" to the title to clarify. Some more details of the research recommendations in relation to women with obesity are given in appendix L of evidence review I. The suggested primary outcomes for this particular research question are: term stillbirth; intrapartum stillbirth; and early neonatal death. Suggested

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					secondary outcomes are: neonatal morbidity (Apgar < 7 at 5 minutes, admission to neonatal unit, shoulder dystocia, macrosomia, and < third and tenth birthweight centiles)
RCGP	Guideline	6	line13	The MDT should include the GP because although we do not usually have a role intrapartum, it is of crucial importance that we make available all information to the specialist team on booking the pregnancy. When there are signs that the mother or baby are at risk, the GP needs to act promptly if consulted, and advocate for the mother if she is not receiving adequate information or care. It is important that we too know what the mother and baby should expect.	Thank you for this comment. A GP has been added to this list
RCGP	Guideline	7	12	Low risk conditions probably need a mention by name, this comment is too vague	Thank you for this comment. To ensure clarity of what low-risk complications are we have added a reference to the modified WHO classification of risk. We do not wish to add specific examples or definitions within the recommendation itself, as recommendations should be succinct. For those with a specific interest in this recommendation they can refer not only to the reference, but to the rationale and impact section of the guideline
RCGP	Guideline	8	5	When pregnancy is confirmed is a bit late. These high risk women need to be assessed pre-pregnancy as part of their usual care	Thank you for this comment. This recommendation, is explicitly directed at care of women who are already pregnant. We would like to draw your attention to recommendation 1.1.3 which recommends that women with known medical conditions should discuss intrapartum care before conception if possible
RCGP	Guideline	9	23	Warfarin is a once daily medication, so maybe this should be phrased differently. Do not give warfarin if it is due..	Thank you for this comment. We agree this recommendation needed clarifying, and we have

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					amended it accordingly. We have also used the general term "anticoagulant" rather than the specific term "warfarin"
Royal College of Anaesthetists	Guideline	12	3	If cardiac output monitoring and serial echocardiography is indicated, it should be made clear to women that in most instances this will necessitate going to the intensive care unit or a delivery suite with the expertise to manage such things. Such units will be few and far between.	Thank you for this comment. We do not think the recommendation itself needs amending, but agree that this should be acknowledged. We have added the following statement to the rationale and impact section: "As part of the clinical review this should be discussed with the woman, and those who require serial echocardiography should be made aware that they are likely to need to go to an intensive care unit or delivery suite where this expertise exists"
Royal College of Anaesthetists	Guideline	16	Table 1	The women in the second category with limited or low fixed cardiac output would need to be advised that they may well need to be treated in specialist centres.	Thank you for this comment. While we agree that women in this category are likely to receive care in a specialist centre, we do not believe this is relevant information to include in the table itself (the woman will already be in the centre in which she is being cared for and so this information is not required)
Royal College of Anaesthetists	Guideline	17	1 to 3	For women with a pre-load-dependent circulation, the aim should be to avoid sudden haemodynamic change when administering oxytocin, for example, by giving a slow infusion rather than a bolus. Suggest avoiding oxytocin bolus in all women with WHO 3 & 4 heart disease (i.e. those in Table 1), or at least women with pulmonary arterial hypertension and coronary artery disease in addition to those with pre-load dependent circulation.	Thank you for this comment. We have revised the wording of Table 1 to make it clearer that women should be offered slow infusion of oxytocin to avoid sudden haemodynamic change
Royal College of	Guideline	17	4 to 11	The asthmatics section appears to cover asthma in general; however, there is no mention of the severe asthmatic/brittle	Thank you for this comment. We did not consider severe asthma to be a particular issue in this section as asthma

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Anaesthetists				asthmatic, who are more challenging and in whom poor care could lead to serious morbidity. As mentioned above, the choice of areas to be covered in this section is difficult to understand.	attacks do not occur during the intrapartum period because of higher levels of adrenaline in the system, except in some rare cases when the woman has a coincidental pneumonia. We had a specific scope for this section that looked at the benefits and risks of different analgesic agents, and the safety of prostaglandins and other uterotonics in women with asthma. There was no evidence to support any different approach to these for women with severe asthma
Royal College of Anaesthetists	Guideline	21	Table 2	The abbreviation should be 'ITP' for immune thrombocytopaenic purpura and not 'IPT'.	Thank you for this comment. The typographical error has been corrected
Royal College of Anaesthetists	Guideline	24	1to3	The guidelines deal with intrapartum care, but they do not mention the use of Magnetic Resonance Imaging (MRI), to exclude spinal vascular malformation in a small group of patients with genetic predisposition to multiple vascular malformation, to enable regional analgesia/anaesthesia to be used.	Thank you for this comment. As you note, this issue affects a small group of people and usually the genetic burden would already be known, therefore, MRI would have already been taken earlier or at least during the antenatal period. MRI in the intrapartum period would not be feasible. However, to make sure that we cover people with unknown genetic history, we have amended the wording of the recommendation to include women with unknown genetic history
Royal College of Anaesthetists	Guideline	25	15-19	In a patient with acute kidney injury the severity of the injury should be taken into account and for those with significant injury particularly if deteriorating, the Observations of heart rate, BP, fluid input/output and oxygen saturations should be more frequent than 4 hourly.	Thank you for this comment. The recommendations about monitoring fluid balance in women with kidney disease have been amended to state that the 4-hourly measurements recommended are in addition to taking

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					hourly heart rate in line with the NICE guideline on intrapartum care for healthy women and babies (CG190)
Royal College of Anaesthetists	Guideline	27	16-17	The notification should include renal transplant surgeons when women with renal transplant are in labour, not just when they have a planned caesarean section. This would be particularly important if there is likely to be delay in obtaining advice should it be needed ie if there is not expert advice available in the hospital where the mother is delivering.	Thank you for this comment. We have deleted this recommendation and inserted a new one that covers planning the intrapartum period in general (not only in case of caesarean section) for women with kidney transplants, including involving a kidney transplant surgeon
Royal College of Anaesthetists	Guideline	27	After 17	It is noted that for renal disease, there is no mention of oxytocics, with their well-recognised anti-diuretic properties. The RCoA queries why this is. At the very least, it is suggested that it should be advising using them in fluid-limited infusions, rather than just added to a bag of fluid.	Thank you for this comment. This is a good point. In particular, we recognise that the antidiuretic effect of oxytocin is more often associated with pulmonary oedema in pregnant women with heart failure due to poor left ventricular function rather than with kidney disease. Under these circumstances, we recognise that the clinician must balance the risk of limiting the volume of fluid in which oxytocin is diluted against the abrupt haemodynamic effect of a bolus dose of oxytocin. We have added this point in the committee's discussion of the evidence section in evidence review C and emphasised the need for clinicians with experience in managing fluid balance in pregnant women with heart disease
Royal College of Anaesthetists	Guideline	27	Section 1.9	The dismissal of obesity is unsupported. Obesity is one of the biggest challenges faced on the labour ward and this section is very brief. It is noted that heart disease has been given 10 pages within the document, and obesity only 2 pages. Perhaps it was intentional to avoid details especially regarding women with BMI>50. However,	Thank you for this comment. We do not think that obesity has been dismissed in this guideline, but as it is a guideline covering several different medical conditions and obstetric complications the clinical areas covered in the scope had to be prioritised and thus the focus is on specific review questions which we sought evidence for.

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				it is suggested for this to be expanded or, as with some other topics, the subject be made the focus of a separate guideline.	We agree that obesity is a big challenge for maternity services yet the evidence for this population is relatively scarce. We have made four research recommendations in relation to women with obesity which could inform future guidance
Royal College of Anaesthetists	Guideline	32	Table 3	Query whether this table is required in the document, given that all the recommendations are the same. Suggest removing the table.	This table has been retained as it sets out the frequency of monitoring recommended in the NICE guideline on intrapartum care for healthy women and babies (CG190) and it allows a convenient comparison with the corresponding table for more severe complications such as sepsis that require additional or more frequent monitoring. However, the table has been simplified to contain a single row as the types and frequency of monitoring are the same for all complications included in this table
Royal College of Anaesthetists	Guideline	33	Table 4	Recommend to add a column of frequency of fetal monitoring.	Our review question is about maternal observations for all women covered in the guideline in terms of having obstetric complications or no antenatal care and this question does not cover fetal monitoring (although this is covered elsewhere in the guideline in relation to some specific complications)
Royal College of Anaesthetists	Guideline	37	1.13.12	It should be emphasised that this recommendation relates to the use of the birthing pool as a form of analgesia in labour because otherwise it could appear to have been inserted randomly, within a section about management of suspected sepsis.	Thank you for this comment. This recommendation has been edited to clarify that the birthing pool would be considered as a form of analgesia
Royal College of	Guideline	41	20-24	If a woman with intrapartum bleeding has a large blood loss or her condition causes concern, the guidelines should include the	Thank you for this comment. Cross-matching has now been added to the recommendation. Taking blood for

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Anaesthetists				recommendation to 'cross match blood'. In addition, 'taking blood for clotting studies and blood gases' should be in the section above rather than under section entitled 'Additionally management may include'.	clotting studies and blood gases has been retained in the second list of bullets so that when recommendations 1.14.5 to 1.14.7 are read sequentially the actions are in a logical order
Royal College of Anaesthetists	Guideline	42	9to12	Context is required in terms of the degree of risk of serious complications for mother and baby. If this guideline is for the mothers and their birth companions to read as is stated, these rather bold statements could be very distressing, as they seem to leave no safe delivery option. This section should be reviewed.	Thank you for this comment. The context of this recommendation is a discussion about "the possible benefits and risks of vaginal birth and caesarean section" for a woman presenting with a breech position in labour. No mode of birth is completely without risk and the recommendation is intended to ensure that the woman is well informed about the different risks associated with alternative modes of birth. It would be expected that the discussion of "benefits" would put "increased chance" within the context of a low absolute risk
Royal College of Anaesthetists	Guideline	47	4	It is unclear whether this section is talking about women who were planning a VBAC (vaginal birth after caesarean), or those who wanted a caesarean but present in labour. The two groups are quite different, as the former should already have received all the information outlined. Clarification is required.	Thank you for this comment. The review protocol in appendix A of evidence review S stated that women who had planned an elective caesarean section should be considered as a separate group in the evidence review and the evidence analysed separately. However, the available evidence did not allow separation of results for this subgroup. Therefore, recommendations did not make a distinction between women with previous caesarean section who had planned an elective caesarean section or a vaginal birth. We agreed that the recommendations are applicable to both groups of women. However we also agreed that discussions in labour should be tailored to the woman's individual circumstances, including any antenatal

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					discussions that she may have already had. In the section on information for women with obstetric complications or no antenatal care, the guideline includes a recommendation to provide information about care in labour and mode of birth which is personalised to the woman's circumstances and needs. We have now also added a recommendation in the risk assessment section recommending to take account of the whole clinical picture when discussing options for care with the woman during the intrapartum period
Royal College of Anaesthetists	Guideline	47	Section 1.19	In this section on previous caesarean section, it is recommended that guidelines should propose vigilance for signs and symptoms of wound dehiscence and uterine rupture including extra care in women with epidural analgesia.	Thank you for this comment. We consider that this is accepted practice and that recommendations cannot cover every aspect of care. Including the extra information in the recommendations would result in too much detail for this guideline
Royal College of Anaesthetists	Guideline	48	1to5	It is noted that there are no recommendations about fetal monitoring for women who have had a previous caesarean section and who are now having a vaginal birth. In the rationale and impact section the lack of evidence as to whether continuous fetal monitoring should be used is noted and the proposition made that research be carried out. In light of this uncertainty the RCoA is concerned that water birth may not be a suitable option as it precludes continuous fetal monitoring and women cannot make an informed decision as there is no evidence.	Thank you for this comment. The NICE guideline on intrapartum care for healthy women and babies (CG190) recommends that telemetry be available to support the use of continuous cardiotocography where it is needed, and it is this which underpins the recommendation to support a full range of options for pain relief for women who have had a previous caesarean section, including labour and birth in water
Royal College of	Guideline	7	15	Suggestion to add the phrase in red below: "whereas others will need specialist care and may need to be	Thank you for this comment. We feel the wording should remain as it is because this recommendation is describing the level of care that women may need in relation to their

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Anaesthetists				delivered in a specialist unit." It is deemed disingenuous to suggest to women with heart disease that they could all be delivered in their local unit or birth centre.	risk, rather than specifying where care will take place. The recommendation highlights that some women will need more specialist care than others
Royal College of Anaesthetists	Guideline	7	Section 1.3	In reference to Heart disease, towards the end of the guideline it states that 'Intrapartum' covers the period from onset of labour to 24hrs after birth. In the management of women with cardiac disease, there is no mention of post-delivery care (other than 3rd stage management). It is recommended that the guidelines mention HDU care for the first 24-48hours for those with significant cardiac disease (In contrast under, the 'patients with renal impairment during pregnancy' section 1.8.10, there is a segment on care up to 24 hours post-delivery).	Thank you for this comment. We agree that care for the woman does not stop 24 hours after the birth, however, for women with heart disease, this is outside of our scope. The recommendations vary between women with renal disease and women with heart disease because the scope of the guideline was different for these two areas of care; the section on heart disease specifically included consideration of the third stage of labour and not beyond this. We did not review the evidence for this time period, and therefore cannot make recommendations
Royal College of Anaesthetists	Guideline	8	4	Suggested that the management of anticoagulation for women with mechanical heart valves should also be included at the beginning of this section. The involvement of haematologists is very much part of the MDT.	Thank you for this comment. We agree that the multidisciplinary team that cares for a woman with mechanical heart valves should include a haematologist, and for this reason the recommendation refers to section 1.2 of this guideline. The members listed in the multidisciplinary team are only examples of who "may" be included; we are not excluding any specialists. To help clarify this point we have added "a physician with expertise in the medical condition", which in the case of a woman with a mechanical heart valve would include a haematologist
Royal College of	Guideline	General	General	The RCoA welcomes the involvement of Obstetric anaesthetists in the writing of this guideline.	Thank you for this comment in support of the guideline

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Anaesthetists					
Royal College of Anaesthetists	Guideline	General	General	Whilst this is an important topic, the points of focus of the guideline are questioned because, although there is an explanation of how the topics have been chosen, there is no clear reasoning as to how the extent of the guidance for each condition has been decided upon. For some conditions such as renal disease, the guidance extends beyond 3rd stage whereas for others, such as heart disease, it seems to stop at that point.	Thank you for this comment and for raising this issue. It was not possible to include every medical condition or obstetric complication not covered by other NICE guidance within this guideline, nor to consider each medical condition or obstetric complication that was prioritised for inclusion in the guideline in terms of every aspect of care that would be relevant in the intrapartum period. A thorough scoping exercise was undertaken prior to guideline development in order to determine what topics and areas should be covered. As part of this scoping exercise stakeholders were invited to attend a workshop to discuss the draft guideline scope. In addition stakeholders were given an opportunity to comment on a revised draft of the scope and the developer's responses to the comments on the draft scope are published on the NICE website. The prioritisation exercise identified certain areas, such as intrapartum care for women with heart disease, and intrapartum care for women with sepsis, as strong drivers for development of the guideline. This is because of the proportion of maternal deaths associated with these conditions. The sections of the guideline that relate to these conditions are, therefore, more comprehensive in coverage than those for some other conditions or complications for which very specific review questions were identified for consideration

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Royal College of Anaesthetists	Guideline	General	General	In some cases such as asthma, obesity and management of women with small or large for gestational age babies, there is really very little in the guideline. Whilst it is made clear elsewhere that this is because the review group have concentrated on factors that are not covered in other guidance and which could cause serious morbidity or mortality, the RCoA feels that some professionals and many patients and their families could be confused by this approach and feel that information is missing. Perhaps the title of the guidance or the initial explanatory notes could be changed to make this clearer.	Thank you for this comment; as you acknowledge it is made clear that the evidence reviews have concentrated on factors not covered in other guidelines. We think that this is clear to the readers of the guideline, and therefore do not think the headings need changing. We would also like to highlight that throughout the guideline readers are signposted to other relevant guidelines, and thus do not agree that more detail is needed
Royal College of Anaesthetists	Guideline	General	General	The RCoA feels that there is insufficient emphasis on the necessary interaction between Obstetrics and critical care for these patients , and also notes that the document does not appear to reference the 'Care of the critically ill women in childbirth; enhanced maternal care' guideline	Thank you for this comment. The guideline committees included expertise in obstetrics and critical and the "Care of the critically ill women in childbirth; enhanced maternal care guideline" was not published until August 2018, which was too late for it to be considered by this guideline which had concluded the development phase by then. Furthermore, there is a considerable emphasis on multidisciplinary working throughout the NICE guideline which is entirely consistent with the MCC guideline
Royal College of Anaesthetists	Guideline	General	General	It is suggested that it would be a good idea to include the importance of multidisciplinary training within the document.	Thank you for this comment. Multidisciplinary training is outside the scope of the guideline
Royal College of Nursing (RCN	Guideline	1	1	"Intrapartum care for women with existing medical conditions or Obstetric complications and their babies" - A good opening front page saying what the guidance covers and who it is for. The contents pages 3 and 4 are set out in a clear and logical order.	Thank you for this comment in support of the guideline

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Midwifery Forum)				* NICE always remind us of the importance of taking the whole clinical picture into account when planning care*	
Royal College of Nursing (RCN Midwifery Forum)	Guideline	11	14/15	Good to see cardiomyopathy discussed although not mentioned in too much detail. There is little known about peripartum cardiomyopathy and with more understanding mothers will be able to have better treatment. (For information, The British Heart Foundation are funding research into heart failure and on this topic, the first of its kind in the UK – so will need to keep an eye on this for research as its findings may inform future update of the guideline).	Thank you for this comment in support of the guideline
Royal College of Nursing (RCN Midwifery Forum)	Guideline	21	1to2	Blood disorders can often prove complicated for midwives to manage and the information provided within this section was most helpful. A particularly useful aid for managing the third stage of labour for women with thrombocytopenia (this can be stressful) is Table 2 Modifying the birth plan according to platelet count.	Thank you for this comment in support of the guideline
Royal College of Nursing (RCN Midwifery Forum)	Guideline	28	14/15	Within this section on Obesity - raised BMI advice is given for the woman to adopt the left lateral position in the second stage of labour. Evidence remains limited and on pages 72/73 explanation is more or less provided. We need to remember each woman as an individual and as practitioners being empathetic and an advocate. Risk assessment and planning care for these women is key.	Thank you for this comment. We agree that individualised risk assessment and planning involving the woman is key and we think that the recommendations reflect this
Royal College of Nursing (RCN Midwifery Forum)	Guideline	28	7to13	A good point made - that for women with a BMI over 30 kg/m2 at the booking appointment, to carry out a risk assessment in the third trimester and when developing the birth plan, take into account: the woman's preference - the woman's mobility - comorbidities - the woman's current or most recent weight	Thank you for this comment in support of the guideline

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Royal College of Nursing (RCN Midwifery Forum)	Guideline	34	1	The entire section on sepsis was thorough and excellent (pages 32 – 39). Table 4 provide a good reminder / aid to the Observations essential to good care when looking after women with fever / sepsis.	Thank you for this comment in support of the guideline. Some edits have been made to the recommendations after discussing your comments. For example, a recommendation has now been edited to state that for women in labour with sepsis and signs of organ dysfunction, regional anaesthesia should only be used with caution and advice from a consultant obstetric anaesthetist, and with a senior anaesthetist present. Before consultation, this recommendation stated that a consultant obstetric anaesthetist should be present. However, we discussed this and agreed that that the consultant obstetric anaesthetist does not always need to be present, and stating they must be present is too restrictive and may delay appropriate care. Some edits have also been made to table 4. In relation to women in labour with fever or suspected sepsis with insufficient concern to start antibiotic treatment, the table now recommends assessing the level of consciousness (using the "alert, voice, pain, unresponsive" (AVPU) framework) hourly. Before consultation, the guideline indicated that this did not need to be checked routinely for these women. We have discussed this and we agreed that the level of consciousness is often assessed automatically with the checking of other parameters, and so we have now added frequency of assessment of the woman's level of consciousness. We have based the frequency on our expertise and consensus and taking into account the frequency of assessments of other parameters. For

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					women in labour with sepsis or suspected sepsis where antibiotic treatment is needed, the table now recommends checking the level of consciousness every 30 minutes. Before consultation, the table only recommended using clinical judgement in relation to assessing the level of consciousness for these women. We have now recommended a frequency, based on our expertise and consensus and taking into account the frequency of assessments of other parameters. Moreover, we have added a footnote to the table indicating that the frequency of observations should be adjusted if necessary based on the level of clinical concern
Royal College of Nursing (RCN Midwifery Forum)	Guideline	43	1 (1.16)	This discusses care of women with small for gestational age (SFG) babies and predominantly Cardiotocography (CTG) monitoring in labour. We had expected a mention of the Growth Assessment Protocol (GAP) programme which is acknowledged in the NHS document 'Saving Babies' Lives A care bundle for reducing stillbirth'. The algorithm demonstrated within there is helpful and many trusts use it. Some thought may need to be given in the future for CTG guidance as now many UK units are using the FIGO (The International Federation of Gynecology and Obstetrics) standards.	Thank you for this comment. The Growth Assessment Protocol (GAP) combines three core elements, including Gestation Related Optimal Weight (GROW) and a package of support. The tools referred to in the comment are widely used in practice, but relate to fetal monitoring and detection of growth restriction during the antenatal period rather than fetal monitoring during labour. The scope of this guideline is intrapartum care, and therefore inclusion of discussion relevant to antenatal care is outside the scope of the guideline. How to perform and interpret continuous cardiotocography is discussed in the NICE guideline on intrapartum care for healthy women and babies (CG190), which was updated in 2017 following publication of the FIGO guidance

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Royal College of Nursing (RCN Midwifery Forum)	Guideline	5	2	Section 1.1: Currently there is no mention of smoking in the guidance. We consider that guidance in this area would be helpful. There is a breadth of evidence which suggests that pregnant smokers have an increased risk of complications during birth; and should therefore be considered as higher risk and planning for birth should follow accordingly. The recently published report by Challenge Group ('Review of the Challenge 2018') and the recent Royal College of Physicians report on smoking and the NHS, outlines some of the key messages for healthcare professionals about the risk factors in pregnancy.	Thank you for this comment. The scope excluded "women in labour who are identified before or during labour to be at high risk of adverse outcomes solely because of personal or social circumstances" (https://www.nice.org.uk/guidance/gid-cgwave0613/documents/final-scope-2). There is existing NICE guidance on smoking in pregnancy, including smoking [stopping in pregnancy and after childbirth] (PH26) and smoking [acute, maternity and mental health services] (PH48). In addition there are NICE guidelines on antenatal care for uncomplicated pregnancies (CG62) and pregnancy and complex social factors (CG110) which address smoking in pregnancy. Intrapartum care for women who smoke would not be different from that for women at low risk in the intrapartum period, although where the associated obstetric risks of smoking, such as low birthweight, fall within the scope of the guideline the baby is identified in labour to be at high risk of adverse outcomes and will be covered by this guideline
Royal College of Nursing (RCN Midwifery Forum)	Guideline	7	16	The newly described Looeys Dietz syndrome is a little known genetic disorder and it is good to be included here, the majority of practitioners will want to research to know more about the syndrome.	Thank you for this comment in support of the guideline

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Royal College of Nursing (RCN Midwifery Forum)	Guideline	7	22	A new term? NYHA classification (New York Heart Association classes 1 – 4), most practitioners will only be familiar with WHO classification?	Thank you for this comment. We have added the reference: https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure
Royal College of Nursing (RCN Midwifery Forum)	Guideline	General	General	The Royal College of Nursing (RCN) welcomes proposals to develop guidance on Intrapartum care for women with existing medical conditions or Obstetric complications and their babies. The RCN invited members who care for pregnant women and their babies to review the draft document on its behalf. The comments below reflect the views of our members.	Thank you for this comment in support of the guideline
Royal College of Nursing (RCN Midwifery Forum)	Guideline	General	General	Overall this is a huge yet comprehensive informative document which highlights the need for the content. All relevant medical conditions and complications appear to be included. For practitioners, it will form a much required learning tool. It embraces recommendations from the MBRRACE, Better Births reports and information from the Department of Health, Royal College of Obstetrics and Gynaecology and Royal College of Midwives. This guidance will require training in application for effective implementation. It can be used for continuing professional development (CPD) post registration midwifery education in 'High Risk Maternity Care Modules'. It would be good if it can be introduced into maternity mandatory	Thank you for this comment which will be considered by NICE where relevant support activity is being planned

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				training in NHS trusts. It will and most likely form as a benchmark in the writing of local guidelines, policies and procedures. The reality is that women with complicated pregnancies who realise they have choice are often managed in their own local units not necessarily transferred to tertiary centres as was often seen in the past, so practitioners need to know how to care for these women. The importance of care utilising the multidisciplinary team is highlighted throughout. Recommendations made on the whole appear to be in line with what is generally happening in clinical practice. Links in each section were helpful to check rationale and impact on practice. Links to the pertinent NICE guidance were also a useful aid (as some cross-references) i.e. Intrapartum care for healthy women and babies plus Pregnancy and complex social factors . Costing is always an issue when introducing new ways of working and care planning. We note that NICE have made available their economic models in support of this guidance. This may need a separate discussion at local level and to tailor local need.	
Royal College of	Guideline	1	6	2nd bullet point – should this bullet point also include 'or who have a planned caesarean section'?	Thank you for this comment. This text, taken from the guideline scope (https://www.nice.org.uk/guidance/gid-

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Obstetricians and Gynaecologists					cgwave0613/documents/final-scope-2), is included in the draft guideline for consultation but not in the final guideline. The scope cannot be changed at this stage but the guideline population does include women with a planned caesarean section in spontaneous or induced labour who are identified as being at high risk of adverse outcomes because of obstetric complications
Royal College of Obstetricians and Gynaecologists	Guideline	10	10	'time off' anticoagulation is open to misinterpretation – perhaps to 'minimise time with deliberately reduced anticoagulation'	Thank you for this comment. We have removed this phrase from the recommendation and do not think any replacement text is required
Royal College of Obstetricians and Gynaecologists	Guideline	10	12to 18	Please comment on Anaesthetist role if C Section is decided	We did not understand this comment, but it was agreed that an anaesthetist does indeed play a role
Royal College of Obstetricians and Gynaecologists	Guideline	15	16-18	Active management of the 3rd stage of labour should be considered +/- offered to all women giving birth	Thank you for this comment. We agree with you and would like to clarify that active management is indeed considered in the NICE guideline on intrapartum care for healthy women and babies (CG190), to which this recommendation refers
Royal College of	Guideline	15	16 to 18	If LMWH is continued during labour then recommendations for the timing of epidural catheter removal are required	Thank you for this comment. We agree that this was an oversight and have added a recommendation for those

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Obstetricians and Gynaecologists					women who continue on low-molecular-weight heparin. We have also amended the rationale and impact section to acknowledge the importance of providing details regarding the appropriate timing for removal of the epidural catheter for women who remain on low-molecular-weight heparin
Royal College of Obstetricians and Gynaecologists	Guideline	17	16-20	Might be helpful to state names of PGE1 and PGF drugs	Thank you for this comment. We have added examples of PGE1 and PGE2 drugs in the recommendation
Royal College of Obstetricians and Gynaecologists	Guideline	19	1 to 3	Much greater clarity comes from: Given that the limited available evidence was not able to show at which level of platelet count or platelet function the risk of complications, such as epidural haematoma, starts to increase, and no serious harm was found from regional analgesia or anaesthesia even with a platelet count below 50 x 109/l, the risks and benefits should be discussed with women. This risk-benefit ratio will be highly individual and could change in the intrapartum period. This is particularly relevant in this area of practice given that arbitrary cut-offs are widely used, and these are clearly based on no evidence (there were no cases of haematoma in over 2000 cases quoted in Evidence Level F). If we're making evidence based guidelines, let's ensure that clinicians are aware of the lack of	Thank you for this comment. We think the content in the rationale and impact section cited by you is too detailed to include in a recommendation about a discussion of the balance of risks of regional analgesia and anaesthesia with women with bleeding disorders, especially as the risks are highly individualised and can be fluid over the intrapartum period. However, we would expect any such discussion to be informed by the type of content covered in the rationale and impact section

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				evidence on which decisions are currently being made. An Obstetric GA is a risky procedure and a regional technique is likely to be safer with a platelet level <80, but is currently rarely offered.	
Royal College of Obstetricians and Gynaecologists	Guideline	19	Whole section	The recommendations do not adequately cover all the relevant aspects of care for women with bleeding disorders in labour. I would strongly urge NICE to refer to the relevant RCOG Green-top guideline	Thank you for this comment. This guideline looked at different bleeding disorders but found very little evidence. It therefore focused on more prevalent conditions such as low platelet count. There are cross-references to the RCOG guideline on management of inherited bleeding disorders in pregnancy (Green-top Guideline No. 71) in evidence review F, which presents in full the committee's discussion of the evidence
Royal College of Obstetricians and Gynaecologists	Guideline	20	11 to 21	It is often difficult to tell ITP from gestational thrombocytopenia as both are a diagnoses of exclusion, and it's not possible to 'exclude' pregnancy until after the delivery. This is therefore quite a large group so the recommendation is very important. The evidence base for ITP in 'Evidence Level F' shows 1 neonatal death (respiratory failure in a baby at 27 weeks with no bleed) and no neonatal morbidity events. The incidence of intra-cranial haemorrhage has been described as 1%, but no attempt has been made to look at whether these are related to method of delivery, or specific intra-partum events. Given this, it is not possible to make any recommendations at all about the management of ITP in labour - let alone advice not to carry out an FBS, which may lead to a difficult cesarean section in advanced labour with risks of intra-cranial damage. If the evidence is to presented objectively, the recommendation	Thank you for this comment. The lack of evidence is discussed in the rationale and impact section and the committee used their knowledge and expertise to recommend some precautions to reduce the risk of bleeding in the baby. The 1% of intracranial haemorrhage comes from a review by Payne (1997) where 6 cases of intracranial haemorrhage were observed in 601 births; of the 6 cases, 4 were associated with a vaginal birth and 2 with caesarean section

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				should read: There are very limited data on which to modify intrapartum care for either ITP or gestational thrombocytopenia. Given this, it may be reasonable to consider FBS or instrumental delivery if the risks of cesarean are felt to outweigh the possible risks related associated with continuing a vaginal delivery.	
Royal College of Obstetricians and Gynaecologists	Guideline	21	2	Should the abbreviation be ITP?	Thank you for this comment. The typographical error has been corrected
Royal College of Obstetricians and Gynaecologists	Guideline	24	10	A midwife with expertise in managing renal conditions in pregnant women – this is unrealistic	Thank you for this comment. We did not mean that the midwife should have expertise in managing renal conditions in pregnant women and we see how the wording was unclear. We have therefore amended the recommendation to say the woman should be cared for in the intrapartum period by a midwife, obstetrician and obstetric anaesthetist with input from a specialist with expertise in managing renal conditions in pregnant women
Royal College of Obstetricians and	Guideline	25	9to11	What is meant by prolonged labour? Realistically, checking renal function every 24 hours will mean once during labour.	Thank you for this comment. Sometimes labour might last longer than 24 hours, therefore, we found it important to make sure that renal function is assessed at least every 24 hours during the intrapartum period

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Gynaecologists					
Royal College of Obstetricians and Gynaecologists	Guideline	26	5to7	Tables 3 and 4 imply that maternal pulse should be measured hourly in labour yet for women with renal impairment this can be 4 hourly – this cannot be correct?	Thank you for this comment. The recommendations about monitoring fluid balance in women with kidney disease have been amended to state that the 4-hourly measurements recommended are in addition to taking hourly heart rate in line with the NICE guideline on intrapartum care for healthy women and babies (CG190)
Royal College of Obstetricians and Gynaecologists	Guideline	27	20-22	So a scan should be performed in all women at the start of established labour if the baby's presentation is uncertain. Once again the recommendation is really woolly – why put BMI 30 and particularly 35 – why not 40 or 45 etc?	Thank you for this comment. We recommend that only if the baby's presentation is uncertain, an ultrasound scan should be considered to exclude malpresentation in order to avoid potential adverse events and additional interventions for the woman and the baby. In clinical practice this applies to all women, however, according to our experience it is more common for there to be uncertainty about the baby's presentation in women with a BMI over 30, and particularly women with BMI over 35
Royal College of Obstetricians and Gynaecologists	Guideline	27	Whole section	I think a recommendation about anaesthetic referral for women with BMI >40 should be discussed here as there is an increased risk of Obstetric complications in this group and assessment of airway/intravenous access is often helpful before the onset of labour	Thank you for this comment. This is a good point, however, as the guideline covers intrapartum care for women with medical conditions or obstetric complications the section on obesity had to be kept focused on specific clinical areas that were prioritised as part of the guideline scoping process. As we did not review the evidence we were not able to make a recommendation on the BMI cut-off at which an anaesthetist should be directly involved in intrapartum care. However, we did discuss this and considered that normally an anaesthetist should be made

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					aware if a woman with a BMI over 40 is admitted for birth. This is noted in the rationale and impact section
Royal College of Obstetricians and Gynaecologists	Guideline	27	Whole section	Would also be helpful to have a recommendation about active management of 3rd stage to reduce risk of PPH as these women are at increased risk	Thank you for this comment. As the focus of this guideline is not to cover every aspect of care during labour and birth for women with obesity, the section on obesity was prioritised to cover some specific review questions. Active management of the third stage of labour was not part of the scope for this section and therefore no recommendation was made on this
Royal College of Obstetricians and Gynaecologists	Guideline	28	2to5	This is recommending that in women with a raised BMI, the method of fetal monitoring should be based on Obstetric indications and the woman's preference – what about the technical aspects of trying to monitor the fetal heart rate on women with BMIs of 50 or 60 where a fetal scalp clip is often the only practical way to achieve a satisfactory assessment.	Thank you for this comment. We think that clinical judgement should be used when discussing options with the woman, including when there are particular technical or practical problems with any procedures or interventions
Royal College of Obstetricians and Gynaecologists	Guideline	30	Whole section	I found this section quite confusing How would the authors distinguish between suspected sepsis requiring antibiotics and not requiring antibiotics given the recommendations in the Sepsis 6 bundle? Patients are commenced on antibiotics as soon as cultures are taken and the index of suspicion for sepsis has been raised.	Thank you for this comment. Multiple edits have been made to this section with the aim of improving clarity. Decision-making on whether there is insufficient concern to start antibiotic treatment or whether antibiotic treatment is needed for women with suspected sepsis was beyond the scope of this guideline. As mentioned in the discussion of the evidence section relating to intrapartum care for women with sepsis and mode of birth, we were aware that the NICE guideline on sepsis (NG51) covers the recognition, diagnosis and early management of sepsis for all populations, including pregnant women. We recommend that the guideline on sepsis should be

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					followed for the recognition of sepsis in pregnant women, while allowing for normal physiological changes (such as increased maternal pulse rate) that occur in labour and which are also associated with sepsis. We also discussed decision-making related to whether there is insufficient concern to start antibiotic treatment or whether antibiotic treatment is needed for women with suspected sepsis and noted that the guideline on sepsis includes recommendations on reviewing a person with suspected sepsis for consideration of antibiotics. This has now been added to the discussion of the evidence section for risk assessment for women with obstetric complications or no antenatal care. This guideline does not try to replicate the Sepsis 6 bundle recommendations but was developed with knowledge of its existence while specifically dovetailing with the NICE sepsis guideline
Royal College of Obstetricians and Gynaecologists	Guideline	32	Table 3	All recommendations are the same for all categories. This could be condensed.	The table has been simplified to contain a single row as the types and frequency of monitoring are the same for all complications included in this table
Royal College of Obstetricians and	Guideline	33	Table 4	AVPU – I think 100% of women should be Alert by this classification and any deviation from this should instigate immediate and urgent medical attention. This is assessed often automatically with the checking of other parameters. I think it would be sensible to match	Thank you for this comment. We have discussed this and have now added frequency of assessment of the woman's level of consciousness (using the "alert, voice, pain, unresponsive" (AVPU) framework) to each row of table 4. We have based the frequency on our expertise and

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Gynaecologists				AVPU assessment to that of the most frequent assessment of other parameters in each row.	consensus and have also taken into account the frequency of assessments of other parameters in each row. Moreover, we have added a footnote to the table indicating that the frequency of observations should be adjusted if necessary based on the level of clinical concern
Royal College of Obstetricians and Gynaecologists	Guideline	33	Table 4	For intrapartum haemorrhage- PR Hourly is not acceptable, should be at least 30mts interval and BP again needs more closer Observations and not 4 hourly	Thank you for this comment. The recommended frequency for monitoring the maternal pulse for women with intrapartum haemorrhage is "at least" hourly, and so if healthcare professionals decided to monitor the maternal pulse every 30 minutes based on their clinical judgement, their decision would be in line with the recommendations. Likewise, the recommended frequency for monitoring blood pressure for women with intrapartum haemorrhage is "at least" 4-hourly, and "at least" hourly in the second stage of labour, and so monitoring could be performed more frequently if this was deemed appropriate using clinical judgement. A footnote has now been added to the table stating that the frequency of observations should be adjusted if necessary based on the level of clinical concern
Royal College of Obstetricians and Gynaecologists	Guideline	37	20	This suggests that every FBS should be discussed with the consultant. This seems to avoid over or inappropriate use of FBS, however this presents a risk of delaying appropriate use of FBS which is usually a time critical event.	Thank you for this comment. This recommendation only refers to women with sepsis or suspected sepsis and we agreed that there should always be a discussion with a consultant obstetrician about whether fetal blood sampling is appropriate and any results from the procedure if it is carried out, because fetal blood sample results may be

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					falsely reassuring in this population. This recommendation uses the same wording as a recommendation in the NICE guideline on intrapartum care for healthy women and babies (CG190), which recommends to be aware that for women with sepsis or significant meconium, fetal blood sample results may be falsely reassuring, and there should always be a discussion with a consultant obstetrician about whether fetal blood sampling is appropriate and any results from the procedure if carried out. Therefore, after discussing this comment, we have agreed not to change this recommendation
Royal College of Obstetricians and Gynaecologists	Guideline	39	1to5	There needs to be mention of antibiotics that cover Group B Strep	Thank you for this comment. Broad-spectrum antimicrobials as specified in the recommendation would cover group B streptococcal infection and so we have not made the suggested specific addition to the recommendation
Royal College of Obstetricians and Gynaecologists	Guideline	41	2to8	Include Neonatologist	Thank you for this comment. We have discussed this and agreed that a neonatologist would be included at the birth and when making decisions about expediting the birth, but this recommendation is about management of any vaginal blood loss other than a 'show', so the suggested addition has not been made here. There is a recommendation later in the guideline which mentions that if a woman with intrapartum bleeding has a large blood loss or her condition causes concern, management may include expediting the birth, however that recommendation does

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					not specify which healthcare professionals should be involved in decision-making about expediting the birth, so the suggested addition has not been made there either
Royal College of Obstetricians and Gynaecologists	Guideline	42	14	I disagree with this. This statement infers that this is the primary factor in deciding mode of delivery. There are several situations where breech presentation would warrant Cat 2 caesarean section. The diagnosis of breech presentation in second stage is not mentioned.	Thank you for this comment. The recommendation to offer women in labour with breech presentation a choice between continuing labour and caesarean section has now been moved below all other recommendations on discussions with the woman, so that the woman can make an informed decision. One of these recommendations recommends to explain to women in labour with breech presentation that any benefit of caesarean section in reducing the chance of complications for the baby may be greater in early labour. The discussion of the evidence section mentions that based on the composite adverse perinatal outcome, the Term Breech Trial showed clinically important benefits for the baby from a caesarean section in early labour but only a possibility of clinically important benefits for the baby from a caesarean section in active labour. The committee debated whether there should be 2 separate recommendations, one for labour that is not yet established and one for established labour, but they noted that there is a continuum of risk for the baby over time. They also noted that if the baby's presentation were quite low in more advanced labour then performing a caesarean section could be problematic. Therefore the committee recommended advising women that any benefit of emergency caesarean section in

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					reducing the chance of complications for the baby may be greater in early labour. Moreover, a recommendation has been added to the section on risk assessment for women with obstetric complications or no antenatal care, which recommends taking account of the whole clinical picture when discussing options for care with the woman during the intrapartum period. We have discussed the reference that this comment makes to the diagnosis of breech presentation in the second stage of labour. The recommendations do not make a distinction between women who present in labour after having planned a vaginal birth with a diagnosed breech presentation and women who present in labour with an undiagnosed breech presentation, or women who were planning a caesarean section due to a breech presentation but present in labour. The review protocol included all these groups of women. The review protocol also recommended a subgroup analysis separating women who planned a caesarean section from the other women if heterogeneity was found, but there was no data available for this subgroup analysis. The committee agreed that all the recommendations should apply equally to all these groups of women
Royal College of Obstetricians	Guideline	42	14-15	Why is there no mention of intrapartum ECV – this is a component of the RCOG Advanced Labour Ward Practice ATSM (2018 syllabus)	Thank you for this comment. The review protocol focused on the comparison of emergency caesarean section versus continuation of labour for women with breech

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and Gynaecologists					presentation in labour. As per the protocol, no evidence was reviewed on external cephalic version. However a mention of external cephalic version has now been added to the discussion of the evidence section, which now includes the following: the committee was aware of existing guidance on other aspects of intrapartum care for women with breech presenting in labour (see the Royal College of Gynaecologists (RCOG) management of breech presentation (Green-top Guideline No. 20b)) such as the woman's position during labour and birth and use of epidural analgesia, and felt that their recommendations would complement the existing guidance. The committee agreed that appropriate support for a breech birth includes practices that are likely to reduce unnecessary interventions during labour and birth, such as external cephalic version if the membranes are intact and encouraging women to be mobile and to adopt positions they feel comfortable in (including upright positions), consistent with the NICE guideline on intrapartum care for healthy women and babies (CG190)
Royal College of Obstetricians and Gynaecologists	Guideline	42	16-18	Might this be better as: Advise women in labour with breech presentation that any benefit of caesarean section in reducing the chance of complications for the baby may be less in advanced labour	Thank you for this comment. We have discussed this and agreed not to make the suggested edit because we preferred to follow a chronological order in the recommendations thus highlighting what comes first (early labour) and also because early labour is easier to define than advanced labour

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Royal College of Obstetricians and Gynaecologists	Guideline	42	6to13	Breech presentation in labour. The Evidence Review explains that 'very low quality evidence found no clinically important differences between the groups…'. Intrapartum cesarean section carries significant risks for the mother in the incident pregnancy, and for future pregnancies. The following statements, I feel, more accurately reflect the uncertainties here: Where a woman presents in labour with an unexpected breech presentation, management should depend on the stage of labour, whether factors associated with increased complications are found, the availability of appropriate clinical expertise and her informed consent. Women near or in active second stage of labour should not be routinely offered caesarean section.	Thank you for this comment. We have discussed the reference that this comment makes to the evidence and agreed that many evidence statements in the review refer to no clinically important differences in outcomes between women who had an emergency caesarean section in labour and those who had a vaginal birth, while other evidence statements refer to clinically important differences between the groups. As explained in the discussion of the evidence section, considering that most of the outcomes considered in the review are rare events, it is possible that in many studies the lack of clinically important differences is due to small sample size. The committee noted that the study with the biggest sample size was the secondary analysis of the Term Breech Trial reported in 3 publications (Su 2003, Su 2004, Su 2007). They noted that evidence from this study showed no clinically important difference in maternal infection between caesarean section in early labour and vaginal birth, but a clinically important increase in maternal infection with caesarean section in active labour compared to vaginal birth. The same study showed a clinically important increase in maternal morbidity (a composite outcome including multiple morbidities and complications) during the first 6 weeks after caesarean section in either early or active labour compared with vaginal birth. This was in line with the committee's experience. Therefore the committee wanted healthcare professionals to discuss with women presenting with a

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					breech position in labour that there is an increase in the chance of serious medical problems for the woman with caesarean section. The secondary analysis of the Term Breech Trial showed no increased mortality in the baby or morbidity in either group based on each individual outcome included in the guideline review protocol (stillbirth, neonatal mortality, ventilation required, birth injury and admission to neonatal intensive care unit). However, this study showed a clinically important decrease in a composite adverse perinatal outcome with emergency caesarean section in early labour compared to vaginal birth. This adverse perinatal outcome included not only all the aforementioned outcomes in the review protocol, but also additional outcomes outside the protocol, therefore, it was downgraded for indirectness. However, the committee noted that all the outcomes included in the composite outcome were of interest overall. Moreover, the committee recognised that some adverse outcomes could occur only with a vaginal birth, for example, the baby's head getting stuck. Therefore, based on the results from the Term Breech Trial and the committee's experience and expertise, they agreed that healthcare professionals should discuss with women that there is an increased chance of serious medical problems for the baby with vaginal birth.

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					We have discussed the reference that this comment makes to women presenting in labour with an unexpected breech presentation. The recommendations do not make a distinction between women who present in labour after having planned a vaginal birth with a diagnosed breech presentation and women who present in labour with an undiagnosed breech presentation, or women who were planning a caesarean section due to a breech presentation but present in labour. The review protocol included all these groups of women. The review protocol also recommended a subgroup analysis separating women who planned a caesarean section from the other groups of women if heterogeneity was found, but there was no data available for this subgroup analysis. The committee agreed that all the recommendations should apply equally to all these groups of women. We have discussed the reference that this comment makes to individual circumstances and risk factors that could influence care. A recommendation has now been added to the section on risk assessment for women with obstetric complications or no antenatal care, which recommends taking account of the whole clinical picture when discussing options for care with the woman during the intrapartum period. We have discussed the reference that this comment makes to the availability of appropriate clinical expertise.

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					The section on impact of the recommendations on practice mentions that the committee was aware that training may be needed to fully implement the recommendations supporting vaginal breech birth. Moreover, the discussion of the evidence section mentions that the committee noted the importance of healthcare professionals feeling confident and competent to support women in labour and giving birth vaginally with a baby in the breech position. Ensuring that women who attempt a vaginal breech birth are adequately supported to give birth safely and achieve a positive experience is also important. The committee noted that most healthcare professionals currently practise very few vaginal breech births and it might be helpful to take this into account when balancing risks. Adequate training would be needed to ensure healthcare professionals have the skills to support breech birth. When discussing this comment, we agreed that publishing the guideline should prompt a review of training. We have discussed the reference that this comment makes to the woman's informed consent and we agreed that such consent is key. For this reason, recommendations use words such as "discuss", "explain" and "offer", so there is no need to mention informed consent in the recommendations themselves. We have discussed the reference that this comment

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					makes to women nearing or in the active second stage of labour. The guideline recommends offering women in labour with breech presentation a choice between continuing labour and caesarean section. The rationale and impact section explains that the committee wished to ensure that healthcare professionals give women the opportunity to make an informed choice about mode of birth in this situation. They agreed not to recommend one mode of birth over another, but that following discussion of the likely benefits and risks a woman should be able to decide what is right for her. The guideline also includes a recommendation to explain to women in labour with breech presentation that any benefit of caesarean section in reducing the chance of complications for the baby may be greater in early labour. The discussion of the evidence section mentions that based on the composite adverse perinatal outcome, the Term Breech Trial showed clinically important benefits for the baby from a caesarean section in early labour but only a possibility of clinically important benefits for the baby from a caesarean section in active labour. The committee debated whether there should be 2 separate recommendations, one for labour that is not yet established and one for established labour, but they noted that there is a continuum of risk for the baby over time. They also noted that if the baby's presentation were quite low in more advanced labour then performing a caesarean section could be problematic. Therefore the committee recommended advising women

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					that any benefit of emergency caesarean section in reducing the chance of complications for the baby may be greater in early labour
Royal College of Obstetricians and Gynaecologists	Guideline	42	Whole section	The statements here about advice risks of vaginal breech delivery for baby and the risks of caesarean section are very black and white and potentially alarmist. Written like this the majority of women would chose a section – to reduce the risk to their baby – but the evidence for that being the case isn't so clear cut. The recommendation doesn't stipulate if this is in the unrecognised breech presentation. The balance of risks here is very much dependent on the availability of a trained operator to perform a vaginal breech delivery Planned vaginal birth with an appropriately trained operator has not been shown to increase long term morbidity- the PREMODA study failed to show any difference in neonatal unit admissions, composite neonatal morbidity or mortality. While planned caesarean section carries with it a small increase in immediate complications compared to vaginal birth however the long term risks associated with this option are potentially serious. (Cochrane review 2015)	Thank you for this comment. We have discussed the concern that the recommendations are potentially alarmist and agreed that the priority is to provide accurate information to ensure informed decision-making. We have not, therefore, changed the statements about the chance of serious medical problems. We also agreed that a relative increase in the chance of serious medical problems does not mean a high absolute risk and we agreed that it is accepted clinical practice that this sort of detail should be discussed with the woman, however, due to the limited and very low quality evidence, this guideline could not make recommendations that would specify absolute risk. We have discussed the reference that this comment makes to unrecognised breech presentation. The recommendations do not make a distinction between women who present in labour after having planned a vaginal birth with a diagnosed breech presentation and women who present in labour with an undiagnosed breech presentation, or women who were planning a caesarean section due to a breech presentation but present in labour. The review protocol included all these groups of women. The review protocol also recommended

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					a subgroup analysis separating women who planned a caesarean section from the other women if heterogeneity was found, but there was no data available for this subgroup analysis. The committee agreed that all the recommendations should apply equally to all these groups of women We have discussed the reference that this comment makes to the availability of a trained operator. The section on impact of the recommendations on practice mentions that the committee was aware that training may be needed to fully implement the recommendations supporting vaginal breech birth. Moreover, the discussion of the evidence section mentions that the committee noted the importance of healthcare professionals feeling confident and competent to support women in labour and giving birth vaginally with a baby in the breech position. Ensuring that women who attempt a vaginal breech birth are adequately supported to give birth safely and achieve a positive experience is also important. The committee noted that most healthcare professionals currently practise very few vaginal breech births and it might be helpful to take this into account when balancing risks. Adequate training would be needed to ensure healthcare professionals have the skills to support breech birth. When discussing your comment, we agreed that publishing the guideline should prompt review of training.

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					We have discussed the reference that this comment makes to planned vaginal birth and planned caesarean section. The review protocol focuses on this comparison: emergency caesarean section versus continuation of labour. Based on this, the following references, which were identified by the search in relation to the PREMODA study, were excluded from the review after checking the full text (see list of excluded studies): Azria, E., Le Meaux, J. P., Khoshnood, B., Alexander, S., Subtil, D., Goffinet, F., Factors associated with adverse perinatal outcomes for term breech fetuses with planned vaginal delivery, American Journal of Obstetrics and Gynecology, 207, 285, 2012. Exclusion reason: No relevant intervention. Emergency caesarean section is not assessed as a potential risk factor Goffinet, F., Carayol, M., Foidart, J. M., Alexander, S., Uzan, S., Subtil, D., Breart, G., Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium, American Journal of Obstetrics and Gynecology, 194, 1002-1011, 2006 Exclusion reason: No relevant comparison. Comparing planned vaginal births to planned caesarean sections The following Cochrane review reference was identified by the search:

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					Hofmeyr GJ, Hannah M, Lawrie TA. Planned caesarean section for term breech delivery. Cochrane Database of Systematic Reviews 2015, Issue 7. Art. No.: CD000166. DOI: 10.1002/14651858.CD000166.pub2 This reference was not initially checked full text because it is clear from the abstract that it does not focus on the relevant comparison as it compares planned caesarean section to planned vaginal birth. However following this comment we have checked it full text and this publication has now been added to the list of excluded studies with exclusion reason: No relevant comparison. Comparing planned caesarean section to planned vaginal birth
Royal College of Obstetricians and Gynaecologists	Guideline	43	5	I am really not sure what is meant by 'the chance of serious medical problems for her baby'	Thank you for this comment. This recommendation does not mention any specific outcomes because no evidence was reviewed on the risks associated with the baby being small for gestational age. However, as explained in the rationale and impact section, the committee agreed based on their knowledge and experience that babies who are small for gestational age are at risk of adverse outcomes and that this risk is higher when there is growth restriction or problems with birth. The committee's discussion of the evidence section in evidence review P, under the heading of benefits and harms, mentions that small-for-gestational-age babies are at increased risk of perinatal mortality and morbidity, however most adverse outcomes are in growth-restricted babies (see the Royal College of Obstetricians and Gynaecologists (RCOG) small-for-gestational-age

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					fetus, investigation and management (Green-top Guideline No. 31)). These babies are at increased risk of intrapartum morbidity and mortality and we felt that the risk would be increased further based on gestational age and the progress and events of labour and birth. The committee's discussion of the evidence section in evidence review P also has a subsection on the outcomes that matter the most. This explains our choice of the outcomes that were included in the review protocol on how fetal monitoring should be managed during labour for women with a small-for-gestational-age baby. This choice was based on our consensus about what would be the most important outcomes for these babies that could be influenced by method of fetal monitoring
Royal College of Obstetricians and Gynaecologists	Guideline	43-44	1-23 and 1-18	Sections 1.16 and 1.17 - These discussion should have taken place when the condition is suspected during antenatal ultrasound scans – this does not sit well in an intrapartum care guideline	Thank you for this comment. This guideline focuses on care for women during labour and birth. In the case of women with a suspected small-for-gestational-age baby the priority for inclusion in this guideline was how to conduct fetal monitoring during labour and birth. We agree that considerations about information about, and planning for, labour and birth, should be considered in the antenatal period if possible, and antenatal discussion with the woman should ideally take account of the recommendations in this guideline regarding labour and birth, but this guideline cannot make specific recommendations about antenatal care. In the case of

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					women with a suspected large-for-gestational-age baby, the woman may have chosen (planned) to have a caesarean section, and a decision about this would have occurred in the antenatal period such that discussions of benefits and risks of alternative modes of birth would be included in the discussion. However, this guideline covers women in labour who might have booked an elective caesarean section but in whom labour starts spontaneously before the procedure is due to be performed, and women in whom the suspicion of a large-for-gestational-age baby first arises during labour. In both of these cases it is important to inform the woman fully about the options for continuation of labour or an emergency caesarean section and this is why the topic is included in this guideline
Royal College of Obstetricians and Gynaecologists	Guideline	44	16-18	I am very uncomfortable with this recommendation. The committee could not agree a definition of large for dates The committee agreed that estimating large for dates was difficult Evidence Level Q notes that there was no convincing evidence for one mode of birth over another for women in labour whose babies are suspected to be large for gestational age. The quality of evidence for shoulder dystocia (the main reason for concern for this group) is 'very low quality' Intrapartum cesarean section carries significant risks for the mother in the incident pregnancy, and for future pregnancies. No consideration has been given to previous history – e.g. the mother may have delivered a LFD baby previously.	Thank you for this comment. We believe that it is reasonable to offer maternal choice in the context of evidence that does not support one particular mode of birth over another. However, we have added a recommendation stating "Take account of the whole clinical picture when discussing options for care with the woman during the intrapartum period." This will allow consideration to be given to previous history as raised by you

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				To accurately reflect the evidence base, the recommendation should say: that there is no evidence to routinely offer cesarean section in those considered to have a large for dates baby.	
Royal College of Obstetricians and Gynaecologists	Guideline	45-46	28to3	All unbooked women should have history and examination – it is implied in this section and the ultrasound section – but not explicitly stated to make an estimate of gestational age (LMP/Menstrual cycle/ head circumference / SFH and abdominal palpation). Neither does is state to screen for pre-eclampsia –this is one of the key roles of antenatal care and absolutely is required on first contact with a previous unbooked woman regardless of state of labour.	Thank you for this comment. We discussed this and have now specified in the recommendations that the obstetric and general medical examination of a woman with no antenatal care should include the initial assessment described in the NICE guideline on intrapartum care for healthy women and babies (CG190). We agreed that this would enable healthcare professionals to detect pre-eclampsia. We have now edited the recommendation on carrying out an assessment of the unborn baby, to clarify that this would also include estimating gestational age. We agreed that if ultrasound is not possible, gestational age can be estimated clinically
Royal College of Obstetricians and Gynaecologists	Guideline	46	10	All unbooked women presenting in labour, I feel, should have immediate blood born virus testing rather than solely HIV. Urgent results would inform Obstetric decision on MOD/FBC/FBS/rotational delivery.	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis. Serology for hepatitis C would not be performed routinely. Results for hepatitis B would help with regard to providing immunisation, but this is not so for hepatitis C. Note, however, that syphilis is not blood borne

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Royal College of Obstetricians and Gynaecologists	Guideline	46	10to 14	? What about testing for Hepatitis, might not get results quickly but will help for neonatal immunisation	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis. Serology for hepatitis C would not be performed routinely. Results for hepatitis B would help with regard to providing immunisation, but this is not so for hepatitis C
Royal College of Obstetricians and Gynaecologists	Guideline	46	9	What is the purpose of testing for asymptomatic bacteriuria when the woman is in labour – by the time the result comes back she will have delivered the baby!	Testing for asymptomatic bacteriuria is included in routine urine tests for pregnant women, in line with recommendations in the NICE guideline on antenatal care for uncomplicated pregnancies (CG62). This test is offered in the intrapartum period to women with no antenatal care to offset their previous lack of care. This is explained in the committee's discussion of the evidence section
Royal College of Obstetricians and Gynaecologists	Guideline	47		Previous Caesarean Section- Regarding continuous CTG – its good practice and when we counsel regarding risk of scar dehiscence, one of the risk factor is hyperstimulation and abnormal CTG picked up before scar ruptures	Thank you for this comment. As explained in the committee's discussion of the evidence section in evidence review S, we were aware that continuous cardiotocography is usually advised for women planning a vaginal birth who have had a previous caesarean section because of an increased risk of serious medical problems for the baby. We noted that the NICE guideline on caesarean section (CG132) recommends offering women planning a vaginal birth who have had a previous caesarean section continuous cardiotocography during labour. Therefore, no evidence was reviewed on this topic for this guideline. However, we noted that it is uncertain

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					whether continuous cardiotocography in these circumstances allows risk to be identified sooner than if intermittent auscultation is used. We agreed to include specific recommendations to offer continuous cardiotocography to women in labour with a previous caesarean section if using oxytocin for delay in the first or second stage of labour, or if performing amniotomy, while making a research recommendation to evaluate the clinical and cost effectiveness of intermittent auscultation compared with continuous cardiotocography for women in labour who have had a previous caesarean section to inform future guidance (see appendix L in evidence review S for further details). We also discussed explaining the risk of scar dehiscence to women and agreed that this is accepted practice and so it would not need to be mentioned in the recommendations in this guideline because guidelines are not meant to cover all aspects of care
Royal College of Obstetricians and Gynaecologists	Guideline	48	21-24	Is the increased chance of stillbirth not pre-labour? And, assuming so, a CTG is not specifically relevant, though there may be an increased chance of non-reassuring fetal monitoring in labour, which is the probable justification for the monitoring.	Thank you for this comment. We have discussed this and the recommendations have now been edited to state that continuous cardiotocography should be offered to all women in labour after 42 weeks of pregnancy after a full discussion of the benefits and risks to the woman and her baby. The rationale and impact section explains that no

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					evidence was found for monitoring in labour after 42 weeks of pregnancy and we made recommendations based on our knowledge and experience. The reference to an increased chance of stillbirth has been deleted from the recommendations, however, the rationale and impact section mentions that we were aware of some evidence of an increased risk of stillbirth or neonatal death after 42 weeks and this was consistent with our experience. The committee's discussion of the evidence section also mentions that we were aware of some evidence of an increased risk of intrapartum stillbirth or neonatal death after 42 weeks of pregnancy. This evidence was reviewed in the NICE guideline on inducing labour (CG70), which recommends induction between 41^{+0} and 42^{+0} weeks of pregnancy. The evidence is consistent with our experience. Page 28 of the full version of the NICE guideline on inducing labour (CG70) states that births after 42 weeks of pregnancy are associated with an increased risk of intrapartum and neonatal deaths. This evidence statement was based on non-analytical studies (for example, case reports or case series). The rationale and impact section explains that we made the recommendation outlined above because we were aware of an increased risk of stillbirth or neonatal death after 42 weeks. The fact that this risk arises before labour, as mentioned in the comment, does not mean there is no increased risk during labour and birth, whereas the specific reference to this risk in the recommendations

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					having been deleted means that this will not necessarily be a specific focus of discussions about fetal monitoring for this group of women
Royal College of Obstetricians and Gynaecologists	Guideline	49	7to9	Terms used in this guideline - This is an unusual definition of the intrapartum period (including to 24 hours after birth). If this definition is to be employed then the section on intrapartum haemorrhage (section 1.14), will need to be amended to include primary postpartum haemorrhage.	Thank you for this comment. The inclusion in the definition of the intrapartum period of the first 24 hours after the birth was applied consistently throughout the guideline to allow consideration of, for example, care for women with sepsis or suspected sepsis in the first 24 hours after the birth, which is not covered by another NICE guideline. Postpartum haemorrhage is already covered in the NICE guideline on intrapartum care for healthy women and babies (CG190) and that is why it is not addressed in this guideline
Royal College of Obstetricians and Gynaecologists	Guideline	5	10, 11	Offer information prior to conception	Thank you for this comment, but we are not sure what you are suggesting. The recommendations say "Offer information about intrapartum care in consultations before conception, if possible, and as early as possible during pregnancy ..." and so we think the issue raised is already covered
Royal College of Obstetricians and Gynaecologists	Guideline	5	11to 13	Following on from 1.1.1 and 1.1.2, is this not stating the obvious? Who else would be providing the information?	Thank you for this comment. It was thought to be helpful to specify here that a member of the multidisciplinary team should offer the information as the recommendations about the multidisciplinary team come after these recommendations
Royal College of	Guideline	5	14	Should be offered to women with medical condition by member of MDT, (what about GP)	Thank you for this comment. We have amended the wording in the recommendation to say the MDT "...may

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Obstetricians and Gynaecologists					include, as appropriate..." as the composition of the team will vary depending on the woman's condition and situation. The list is not exhaustive but we agree that often a GP's involvement might be needed and so we have added GP to the list
Royal College of Obstetricians and Gynaecologists	Guideline	53-54	31 and 1-29	Anticoag for valvular disease - I don't agree that the reason women should be switched from warfarin to LMWH by 36 weeks is because heparin has a shorter half-life. LMWH is difficult to reverse if a bleeding problem was to arise – (certainly more difficult than warfarin) – the reason we should consider switching is because LMWH does not cross the placenta and unlike warfarin, does not anticoagulate the baby. The pros and cons of LMWH vs heparin need to be considered and discussed with the woman (including the risk of valve thrombosis).	Thank you for this comment. We have amended the rationale to state that "heparin has a shorter half-life than warfarin and it does not cross the placenta unlike warfarin and so reduces the risk of bleeding in the baby"
Royal College of Obstetricians and Gynaecologists	Guideline	56	17	No need for the word 'of'	Thank you for this comment. The typographical error has been corrected
Royal College of Obstetricians and Gynaecologists	Guideline	6	1to2	Should this read 'Intrapartum care planning' rather than 'Antenatal care planning'?	Thank you for this comment. The wording has been amended to refer to antenatal care planning for the intrapartum period

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Royal College of Obstetricians and Gynaecologists	Guideline	6	13-23	Please include GP	Thank you for this comment. A GP has been added to this list
Royal College of Obstetricians and Gynaecologists	Guideline	6	14	Consider replacing should with could	Thank you for this comment. We have replaced "should "with "may"
Royal College of Obstetricians and Gynaecologists	Guideline	63	5to6	Long term steroids - I am not convinced that a planned elective caesarean section more physiologically stressful than a vaginal birth – this really needs to be justified or left out altogether.	Thank you for this comment. We agree with you and have taken out the sentence as it is subjective and does not accurately reflect the actual reasoning behind the recommendations. Labour is a gradual process for which we recommend hydrocortisone 50 mg 6-hourly until 6 hours postpartum. During the intrapartum period, women who labour might actually receive a higher total dose of supplemental hydrocortisone compared with women who have a caesarean section, as the latter group will usually have given birth after a shorter time. Only for women who require steroid supplementation prior to a caesarean section and who have not received earlier doses of hydrocortisone in labour do we recommend a single loading dose of hydrocortisone 100 mg when starting anaesthesia. Similar to women who have given birth

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					vaginally, we recommend that women who have had a caesarean section should have a single further dose of hydrocortisone 50 mg at 6 hours postpartum
Royal College of Obstetricians and Gynaecologists	Guideline	65	14-16	Management of the 3rd stage - There is a fair amount of controversy about recommending 'early cord clamping' – I would urge the guideline development group to review the inclusion of this term in the guideline. This is addressed in the RCOG Green-top guideline on PPH (No. 52) and in NICE clinical guideline 190.	Thank you for this comment. We have removed the word "early" as it is not used in the recommendation from the NICE guideline on intrapartum care for healthy women and babies (CG190) that is being summarised in this sentence
Royal College of Obstetricians and Gynaecologists	Guideline	71	16-18 23-27	Fetal monitoring in women with BMI over 30 - I am not sure what the developers are trying to say here – 'making it even more important to monitor frequently in the intrapartum period' Much of this is covered in the RCOG Green-top guideline on pregnancy in obese women, due to be published soon.	Thank you for this comment. We have amended the wording in this section as it was unclear. We look forward to publication of the RCOG Green-top Guideline on pregnancy in obese women
Royal College of Obstetricians and Gynaecologists	Guideline	8	19	This is a very high risk situation – the guideline needs to be clear – should anti-Xa levels be checked weekly or fortnightly?	Thank you for this comment. For clarity we have amended the recommendation to state that anti-Xa levels should be checked weekly
Royal College of Obstetricians and	Guideline	9	11to 13	This is really vague – clinicians will be looking to this document for more definitive guidance	Thank you for this comment. We do not agree that this recommendation is vague. We have provided clear advice that the woman will need a review by a senior obstetrician and an anaesthetist. The recommendation includes three

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Gynaecologists					options to allow clinicians choice according to their clinical judgement and knowledge of the specific situation
Royal College of Obstetricians and Gynaecologists	Guideline	9	5	Aiming for 'projected' low level of heparin – I think the implication is to use assumed levels rather than test Anti –Xa levels for intrapartum decision making.	Thank you for this comment. You are correct, and a senior obstetrician involved in the woman's care will have the expertise to make a clinical assumption
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	Please include all complex cases example woman with complex cardiac condition, understandably delivery is in tertiary unit with cardiac input, but please communicate the intrapartum management plan to local unit too as delivery timing is often not predictable and it helps local units to organise and plan with available emergency team at that moment	Thank you for this comment. We agree that all healthcare professionals involved in the woman's care should communicate with each other. We have clarified this by adding a further bullet to the recommendation, regarding communication between healthcare professionals
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	This appears to be a comprehensive piece of work. With the explanation of the recommendations being separate from the text itself, which I think takes away some of the clarity from those who'll not be looking in depth, and the fact that most of the recommendations are of 'very low quality', it becomes extremely important to ensure that this uncertainty is clearly reflected in all the recommendations. An introductory sentence, e.g. 1.6.1, 1.6.5, 1.17.3 below. This may require bringing a small amount of justification in (as in suggestion for 1.6.1 below).	Thank you for this comment. The wording of recommendations follows NICE methods as stipulated in the NICE guidelines manual (https://www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf). The strength of each recommendation is used to reflect that some recommendations are underpinned by a greater level of certainty. "Offer" reflects greater certainty, whereas "consider" reflects greater uncertainty
Royal College of	Guideline	General	General	Unofficially, [redacted] is regarded as the UK's foremost expert on Medical Disorders in Pregnancy and [redacted]	Thank you for this comment. A broad range of organisations had the opportunity to register as

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Obstetricians and Gynaecologists				[redacted] (Dublin) the nearest expert in high risk Obstetrics. Their opinion is hugely influential. I suggest that they are offered the chance to review the text prior to publication.	stakeholders and to comment on the consultation draft of the guideline. Key individuals mentioned in the comment are likely to be members of such organisations and therefore could have commented already. Feedback was also provided by two NGA clinical advisors, one of whom is an obstetrician, and their comments have been taken into account when revising the guideline as part of the post-consultation phase
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	The word 'risk' is frequently used in the text. It is a pejorative term often used to describe an increased chance of something happening, and the word 'chance' is therefore often better e.g. 1.20.3 Explain to women in labour after 42 weeks of pregnancy that they have an increased chance of instrumental birth and caesarean section	Thank you for this comment. We agree to some extent with the views expressed by you. We have retained the phrasing of risk when "risks and benefits" are referenced and when the recommendations are aimed at health professionals, especially when potential events imply adverse consequences for the woman or the baby. However, we have used the term "chance" wherever possible in the recommendations that are aimed at sharing information with the woman
Royal College of Pathologists and British Society for Haematology	Evidence review F	Table 1		TTP and antiphospholipid syndrome are not usually considered to be haemostatic problems although they may present with thrombocytopenia	Thank you for this comment. We incorporated these conditions in the population for the literature search for the review question because antiphospholipid syndrome causes venous and arterial thrombosis and thrombotic thrombocytopenic purpura is a micro-angiopathic haemolyticanaemia that is associated with microthrombi and low platelet counts
Royal College of Pathologists	Guideline	19	1	The section entitled Bleeding Disorders discusses both conditions of immune thrombocytopenia (majority of the recommendations)) and coagulation factor deficiencies and congenital thrombocytopenia	Thank you for this comment. This guideline looked at different bleeding disorders but found very little evidence. It therefore focused on more prevalent conditions such as

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and British Society for Haematology				(very minimal discussion). Looking at the Evidence review F, there is a paucity of strong and weighted evidence to support recommendations for patients with congenital bleeding disorders; however there is general consensus in this area over many areas for practice and it is recommended to cross-refer this guidance to the RCOG Green top guide 71 which is a joint collaboration between UKHCDO and RCOG.	low platelet count. There are cross-references to the RCOG guideline on management of inherited bleeding disorders in pregnancy (Green-top Guideline No. 71) in evidence review F, which presents in full the committee's discussion of the evidence
Royal College of Pathologists and British Society for Haematology	Guideline	20	21	Should repeat platelet count in neonate at day 2-5 as it may fall post-partum	Thank you for this comment. This guideline is focused on intrapartum care and therefore the postpartum period is outside the scope of the guideline
Royal College of Pathologists and British Society for Haematology	Guideline	21	Table 2	Typographical error: IPT = ITP	Thank you for this comment. The typographical error has been corrected
Royal College of Pathologists and British Society for Haematology	Guideline	35	12	What is meant by an ongoing multidisciplinary review? Is it intended that delivery units set up a standing team to provide prospective and continuing review and support for the management of sepsis in labour, or is it intended to pull together an ad hoc MDT if and when a woman in labour develops sepsis? Given the shortage of consultant medical microbiologists it seems unrealistic to anticipate that a consultant microbiologist will be available at short notice,	Thank you for this comment. A sentence has now been added to the rationale and impact section on mode of birth for women with sepsis or suspected sepsis to clarify that the intention is that the multidisciplinary team may not meet face to face but that expert advice can be accessed when needed. Moreover, the same rationale and impact section mentions that ongoing review means that the

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				potentially out of hours, to attend an MDT. There is a danger here of creating an undeliverable expectation.	team is prepared to react to a changing situation, which may alter very quickly
Royal College of Pathologists and British Society for Haematology	Guideline	35	6	Please define in the guideline what is meant by suspected sepsis	Thank you for this comment. The definition of suspected sepsis was beyond the scope of this guideline. As mentioned in the committee's discussion of the evidence section relating to intrapartum care for women with sepsis and mode of birth, we were aware that the NICE guideline on sepsis (NG51) covers the recognition, diagnosis and early management of sepsis for all populations, including pregnant women. We recommend, therefore, that the guideline on sepsis be followed for the recognition of sepsis in pregnant women, while allowing for normal physiological changes (such as increased maternal pulse rate) that occur in labour and which are also associated with sepsis
Royal College of Pathologists and British Society for Haematology	Guideline	35	8 et seq	Please define what is meant by senior Obstetrician etc. Do you mean consultant?	Thank you for this comment. The terms "senior" and "consultant" are both used in the guideline as they would be in clinical practice. "Senior" refers to a clinician with expertise in providing care in particular circumstances, whether they be a consultant or a senior registrar with specialist training in the relevant clinical area. Where there is a specific requirement to involve a consultant in the woman's or baby's care this is specified in the recommendations. The term "senior" typically refers to a clinician with at least 5 years' specialty training
Royal College of	Guideline	36	20	Please provide diagnostic features of sepsis originating from the genital tract	Thank you for this comment. A sentence has now been added to the committee's discussion of the evidence

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Pathologists and British Society for Haematology					section on mode of birth for women with sepsis or suspected sepsis to explain that the source of sepsis in labour should be considered to be the genital tract in the absence of any other foci of infection on history or examination. We thought this would be too much detail to include in the recommendation itself
Royal College of Pathologists and British Society for Haematology	Guideline	37	7	As part of good antimicrobial stewardship practice, please include the requirement to take appropriate specimens for microbiological culture, including blood cultures, BEFORE the administration of antibiotics for sepsis	Thank you for this comment. This section is about anaesthesia and analgesia for women in labour with sepsis or suspected sepsis, and so no addition was made here. However there is a section later in the guideline about antimicrobial treatment for women in labour with sepsis or suspected sepsis. In this section, we have now added the recommendation to take specimens for microbiological culture, including blood cultures, before starting antimicrobials. This represents an adaptation of a recommendation in the NICE guideline on sepsis (NG51), which recommends, for patients in hospital who have suspected infections, to take microbiological samples before prescribing an antimicrobial and to review the prescription when the results are available, and, for people with suspected sepsis, to take blood cultures before antibiotics are given. This has now been specified in the committee's discussion of the evidence section relating to antimicrobial treatment for women in labour with sepsis or suspected sepsis Moreover, in the section on management for women with sepsis or suspected sepsis immediately after the birth, we

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					have now added the recommendation that the ongoing multidisciplinary review in the first 24 hours after the birth should include a discussion about the need for microbiological specimens for culture.
Royal College of Pathologists and British Society for Haematology	Guideline	38	16	As part of good antimicrobial stewardship practice, please include the requirement to take appropriate specimens for microbiological culture, including blood cultures, BEFORE the administration of antibiotics for sepsis	Thank you for this comment. We have now added the recommendation to take specimens for microbiological culture, including blood cultures, before starting antimicrobials. This represents an adaptation of a recommendation in the NICE guideline on sepsis (NG51), which recommends, for patients in hospital who have suspected infections, to take microbiological samples before prescribing an antimicrobial and to review the prescription when the results are available, and, for people with suspected sepsis, to take blood cultures before antibiotics are given. This has now been specified in the committee's discussion of the evidence section relating to antimicrobial treatment for women in labour with sepsis or suspected sepsis. Moreover, in the section on management for women with sepsis or suspected sepsis immediately after the birth, we have now added the recommendation that the ongoing multidisciplinary review in the first 24 hours after the birth should include a discussion about the need for microbiological specimens for culture
Royal College of	Guideline	39	16	Please insert "appropriate microbiological specimens" as the first bullet point above "antimicrobial treatment"	Thank you for this comment. We have now added the recommendation that the ongoing multidisciplinary review

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Pathologists and British Society for Haematology					in the first 24 hours after the birth should include a discussion about the need for microbiological specimens for culture. Moreover, in the section on antimicrobial treatment for women in labour with sepsis or suspected sepsis, we have now added the recommendation to take specimens for microbiological culture, including blood cultures, before starting antimicrobials. This represents an adaptation of a recommendation in the NICE guideline on sepsis (NG51), which recommends, for patients in hospital who have suspected infections, to take microbiological samples before prescribing an antimicrobial and to review the prescription when the results are available, and, for people with suspected sepsis, to take blood cultures before antibiotics are given. This has now been specified in the committee's discussion of the evidence section relating to antimicrobial treatment for women in labour with sepsis or suspected sepsis
Royal College of Pathologists and British Society for Haematology	Guideline	46	10	All pregnant women should be offered HIV testing, especially women presenting with no antenatal care. Trying to identify "high-risk" groups for rapid HIV testing risks missing infected women.	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis. However, we decided that the health economic considerations underpinning the recommendation for rapid HIV testing remained valid. The health economic evidence suggested that rapid HIV testing could cease to be cost effective when HIV prevalence is very low. Therefore, we considered it would

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					be cost effective to recommend rapid HIV testing in a context where prevalence would be higher than would result from no antenatal care alone. We are aware that rapid HIV testing services are not yet available throughout the NHS and we did not think the evidence was substantially robust to make a recommendation that would require a rapid HIV testing service to be established even when HIV prevalence is very low
Royal College of Pathologists and British Society for Haematology	Guideline	46	13	Women with a confirmed or suspected history of intravenous substance misuse should also be offered testing for hepatitis B and C, given the possibility of providing prophylactic hepatitis B to the neonate and treatment of hepatitis C positive mothers with directly acting antivirals.	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis. Serology for hepatitis C would not be performed routinely. Results for hepatitis B would help with regard to providing immunisation, but this is not so for hepatitis C
Royal College of Pathologists and British Society for Haematology	Guideline	64	29	Typographical error: fetal = foetal	Thank you for this comment, but NICE style is to use the spelling "fetal"
Royal College of Pathologists and British	Guideline	65	2	Typographical error: fetal = foetal	Thank you for this comment, but NICE style is to use the spelling "fetal"

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Society for Haematology					
Royal College of Pathologists and British Society for Haematology	Guideline	7	1	Is it worth including a comment that antibiotic prophylaxis against endocarditis is not indicated in women with valvular disease? (2015 ESC Guidelines for the management of infective endocarditis. European Heart Journal (2015) 36, 3075–3123)	Thank you for this comment. We agree that this is a valid consideration; however, we did not review the evidence on this topic and are, therefore, are not in a position to make a recommendation
Royal College of Pathologists and British Society for Haematology	Guideline	78	11	Given the shortage of consultant medical microbiologists it seems unrealistic to anticipate that a consultant microbiologist will be available at short notice, potentially out of hours, to attend an MDT. There is a danger here of creating an undeliverable expectation.	Thank you for this comment. The associated recommendation (1.13.5 in the consultation draft guideline) specifies multidisciplinary review and this does not necessarily require attendance at a multidisciplinary team meeting. It would include expert advice provided remotely as well as face-to-face. A sentence has been added to the rationale and impact section to make clear that this is about the provision of expert advice rather than convening a face-to-face multidisciplinary team meeting
Royal College of Pathologists and British Society for Haematology	Guideline	8	17,18	The peak level desired might depend on the valve type, site, heart rhythm and left ventricular function	Thank you for this comment. We agree that the peak level will vary according to the individual woman, hence a range is provided (1 to 1.2 IU/ml)
Royal College of Pathologists and British	Guideline	8	19	Does this refer to management in other trimesters rather than specifically to the switching by 36 weeks, or 2 weeks before planned birth	Thank you for this comment. To clarify, this refers specifically to the third trimester; other trimesters are outside of the scope of this review

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Society for Haematology					
Royal College of Pathologists and British Society for Haematology	Guideline	9	11to 13	Taking into account the justification for this omission on page 54, due to the lack of familiarity of use for many practitioners, intravenous heparin is still used in many units and is the most controllable means of re-anticoagulation in this setting; it should therefore be included in the choice of appropriate anticoagulants as a potential option when bleeding risk is high.	Thank you for this comment. The recommendation has been amended to include the option of unfractionated heparin as suggested
Royal College of Pathologists and British Society for Haematology	Guideline	9	14,15	Dependent on valve type and delivery intermediate or prophylactic doses may be appropriate for a short period of time prior to dose escalation; the advice to re-start therapeutic anticoagulation some hours after delivery will cause a high risk of bleeding	Thank you for this comment. We agree that care will differ according to the woman's specific valve type, and indeed the age and condition of the valve itself; however, it would be unrealistic to list all the different valve types within a recommendation. The cardiologist will be involved in care of the woman and should take into consideration the valve type when assessing risk of bleeding and thrombosis
Royal College of Pathologists and British Society for Haematology	Guideline	9	16-18	Why is 7 days chosen? 5-7 days would enable flexibility to restarting warfarin	Thank you for this comment. The recommendation states "consider", allowing the clinician some flexibility. There is no evidence to support 5 to 7 days; therefore, we do not agree that the recommendation should be amended
Royal College of Pathologists and British Society for Haematology	Guideline	9	23	Does this refer to the with-holding of warfarin?	Thank you for this comment. Yes, warfarin is not to be administered until a senior obstetrician has assessed the woman, thus reducing her risk of bleeding

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Royal College of Physicians (RCP)	General	13	3	Most pregnant women have an ejection systolic murmur - therefore if this is the only sign it would be wrong to consider heart failure – suggest add 'except ESM'	Thank you for this comment. However, we do not think this should be added to the recommendation. It is not necessarily possible at the time of detection to determine what type of murmur is present, although we agree it is important that if a heart sound or murmur is detected then the healthcare practitioner should "think" about the possibility of heart failure. We agree that it is important to raise the profile of heart failure, as this is one of the biggest killers of pregnant women. It is also important that potential signs of heart failure are not overlooked, but we acknowledge, in many cases, having just one of the signs listed and no others does not mean the woman is at high risk. The healthcare practitioner is expected to use their clinical judgement
Royal College of Physicians (RCP)	General	13	4	'crackles and wheeze' should read crackles OR wheeze'	Thank you for drawing our attention to this error, we have amended "and" to "or"
Royal College of Physicians (RCP)	General	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our experts and would like to make the following comments.	Thank you for this comment and all the comments on specific aspects covered in the guideline
Royal College of Physicians (RCP)	Guideline	10	1	No evidence or rationale is provided for the recommendation to continue *any* antiplatelet treatment throughout the intrapartum period. Whereas it is correct that aspirin can be continued intrapartum – it is not the case for clopidogrel and trigagalor. Furthermore it is not clear why antiplatelet agents are being	Thank you for this comment. We agree with you and have therefore removed this bullet from the recommendation

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				recommended for bioprosthetic valves. The evidence section states that the guideline is limited to women with mechanical valves so our experts are unclear why section 1.3.13 is included and suggest its removal.	
Royal College of Physicians (RCP)	Guideline	10	14	Many women with pulmonary hypertension – particularly those with a previous SVD or only mildly raised pressures or those with normalized pressures on targeted therapies can and do have normal vaginal deliveries	Thank you for this comment. We agree with you, hence the recommendation states "consider". This does not mean all women with pulmonary arterial hypertension should have a caesarean section, the ultimate decision will depend on the individual case
Royal College of Physicians (RCP)	Guideline	10	17	Similarly there is no evidence to support the recommendation that women with PHT cannot push and some women who are NYHA III can also push for a short while	Thank you for this comment. We agree that this recommendation should be clarified, and so it has been reworded so that it is clear that the benefits and risks of both an assisted second stage of labour and active pushing alone are discussed with the woman
Royal College of Physicians (RCP)	Guideline	12	25	The cut-off for systolic hypotension of 100 mmHg is in my view too high for a pregnant woman – many normal women have blood pressures below this – so if this was the only sign it would be inappropriate to consider heart failure in every woman	Thank you for this comment. In most cases a systolic reading of 100 mmHg is unlikely to mean the woman has heart failure, and the word "consider" is included for this reason. However, if the woman does have systolic hypotension the healthcare practitioner is expected to use their clinical judgement in considering whether or not this might be due to potential heart failure. We agree that it is important to raise the profile of heart failure, as this is one of the biggest killers of pregnant women. It is also important that potential signs of heart failure are not overlooked, but we acknowledge, in many cases, having just one of the signs listed and no others does not mean the woman is at high risk. The healthcare practitioner is

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					expected to use their clinical judgement alongside these potential signs of heart failure
Royal College of Physicians (RCP)	Guideline	13	1	Cut-off in BTS / SIGN guideline on asthma in pregnancy says <94% not 95%	Thank you for this comment. The SIGN guideline relates to women with asthma who are pregnant, however this recommendation is addressing women who have pulmonary adenoma in the intrapartum period and therefore it is appropriate that the cut-off is less than 95%
Royal College of Physicians (RCP)	Guideline	13	21	For screening for heart failure outside pregnancy NT – BNP would normally be requested before a cardiology review or an echo. Our experts are unsure why order would be different in pregnancy and suggest moving this line up to line 17	Thank you for this comment. We do not agree that one should wait for results of N-terminal pro-brain natriuretic peptide (NT-proBNP) before conducting an echocardiogram, as this would create a delay in getting the information required, which is a clinical opinion about the woman's condition
Royal College of Physicians (RCP)	Guideline	14	1	cMRI would be requested by a cardiologist and is not relevant to guideline on intrapartum management – suggest delete or replace with a suggestion to repeat the TTE	Thank you for this comment. We acknowledge that you make a good point and we have amended the recommendation to reflect the need for continued input from the cardiologist
Royal College of Physicians (RCP)	Guideline	16	Table 1	Our experts suggest the developers use the updated ESC guidelines (2018) to stratify risk of aortopathies and ensure they are consistent with the measurements given in that guideline Our experts suggest that for the oxytocin in the second and third rows, second column it is stipulated that this be given as a slow IV infusion rather than an IV or IM bolus to avoid vasodilation. Currently this point is covered in 1.3.44 but readers looking only at the table could miss this important point and it also assumes the reader understands the phrase 'pre-load dependent circulation' which is optimistic	Thank you for this comment. The table has been amended to include the additional aortopathies addressed in the ESC guidelines (2018), and a reference to this document has been added. We agree that the slow intravenous infusion of oxytocin is an important point and have added to table 1 for clarity

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Royal College of Physicians (RCP)	Guideline	17	1	As above – this is a very important point which is currently too vague and this information needs to be embedded in the table	Thank you for this comment. We agree that this is an important point and we have amended table 1 to include the need to avoid sudden haemodynamic change when administering oxytocin
Royal College of Physicians (RCP)	Guideline	18	5	The developers admit in the rationale section that there is no evidence to inform this section. As such our experts suggest being a bit broader / flexible in the recommendation and say 5-7.5 mg for 2-3 weeks .	Thank you for this comment. We considered this suggestion but agreed that for clarity is it better to keep the recommendation as it is because "5 mg or more" is more flexible than "5-7.5 mg"
Royal College of Physicians (RCP)	Guideline	21	Table 2	There is a typo in table and in the footnote ; 'IPT ' should read ' ITP'	Thank you for this comment. The typographical error has been corrected
Royal College of Physicians (RCP)	Guideline	24-27	AKI / CKD	Our experts note that the whole approach to this section needs to be brought in line with the Renal Association guideline on CKD in pregnancy. Our experts were surprised that the nephrologist was on both guideline development groups and yet the approach taken is different. For the RA guideline we have not used CKD stages because eGFR is not validated in pregnancy. Use of eGFR in pregnancy relies on a pre-pregnancy value (which we will not have in up to 1/3 women). In addition, based on recent cohort CKD3-5 data eGFR is a less important predictor of Obstetric and renal outcome than chronic hypertension and proteinuria. Also a deteriorating CKD 3 may be more high risk and need closer monitoring that a stable CKD 4 – so the distinction (CKD 1-3 and CKD 4-5 in terms of intrapartum management is in appropriate. Similarly it is unclear why on p 26 line 15 you acute lupus nephritis, vascilitis and GN for specialist input singled out and not a woman	Thank you for this comment. We take your point that estimated glomerular filtration rate (eGFR) is not validated in pregnancy. We also agree that progressive or active kidney disease should be considered. We have therefore clarified and amended the recommendations to reflect that: •chronic kidney disease (CKD) staging should be defined according to prepregnancy eGFR •clinicians with expertise in kidney disease in pregnant women should be involved in intrapartum care for women with progressive or active kidney disease (in addition to women with CKD stage 4 or 5) •the option of dialysis and planned birth at no later than 38 weeks of pregnancy should be discussed with the woman and the multidisciplinary team for women with

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				with a renal transplant or nephrotic range proteinuria from FSGS. Similarly we would suggest the term 'AKI' is used in preference to 'renal impairment' and the term 'volume depletion' instead of 'dehydration' Our experts have included below the relevant text of the draft RA guideline in the hope that the 2 guidelines can be cross referenced and not contradict each other or confuse readers. · Women with CKD should be managed during delivery according to NICE Intrapartum Care Guideline (2014, update 2017) and Intrapartum Care for Women with Existing Medical Conditions or Obstetric Complications and their Babies (?2018) · Women with CKD who are at risk of volume depletion or volume overload should be highlighted by the MDT in advance of delivery. · All women with CKD should have Observations taken and documented during any hospital admission. This includes temperature, heart rate, blood pressure, respiratory rate, oxygen saturation, and level of consciousness. An early warning score should be calculated and actioned appropriately. · Additional assessment should be undertaken for women with an elevated early warning score, for women considered to be high risk, and for any women in whom there is any clinical concern. This includes jugular venous pressure, lung auscultation and urine output monitoring (in-dwelling catheter not usually required) in addition to routine parameters. · Fluid balance should be managed with the aim of maintaining normal fluid volume and avoiding dehydration and pulmonary	deteriorating stage 3b CKD (in addition to women with CKD stage 5 or deteriorating stage 4). In relation to the comment about involving a specialist in the care of women with acute lupus nephritis, vasculitis or glomerulonephritis only, we have added the following recommendation: "As early as possible during pregnancy, plan intrapartum care for women with a kidney transplant with the woman, a specialist with expertise in managing renal conditions in pregnant women and a kidney transplant surgeon." We have changed "renal impairment" to "kidney disease". We have kept "dehydration" as it is more familiar in obstetric settings and "volume depletion" might be confused with severe bleeding. As the Renal Association guideline is not published yet, we are not able to cross-refer to it, however, we have added a comment about it in the committee's discussion of the evidence section in evidence review H

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				oedema, with input from clinicians with expertise in fluid balance and renal disease. · Clinicians should be aware of the increased risk of pulmonary oedema in women with CKD and pre-eclampsia. ·In all women with CKD the timing of birth will usually determined by Obstetric indications. Renal indications for preterm delivery (34-37 weeks) may include deteriorating renal function, worsening proteinuria causing symptomatic hypoalbuminaemia or pulmonary oedema, and refractory hypertension.	
Royal College of Physicians (RCP)	Guideline	26	11	While desirable our experts do not think it is practicable to recommend the JVP is assessed every 4 hours for 24 hours after birth in every woman with renal impairment – with current staff mix this is not achievable.	Thank you for this comment. After consideration we have decided to take out jugular venous pressure from the list of observations
Royal College of Physicians (RCP)	Guideline	7	20	The modified WHO classification should use the updated ESC guideline on management of heart disease in pregnancy published April 2018	Thank you for this comment. The reference has been updated, and the recommendation revised
Royal College of Physicians (RCP)	Guideline	8	17	No evidence or rationale is provided for the recommendation to target a peak anti Xa level of 1-1.4 – most practitioners / literature in this field would use 1-1.2 (our experts note that they have even seen 0.8-1 for aortic valves)	Thank you for this comment. We agree with you and have amended the wording of the recommendation so that it now refers to peak levels between 1 and 1.2 IU/ml, in line with the European Society of Cardiology guidelines
Royal College of Physicians (RCP)	Guideline	General	General	As physicians we have limited our comments to the sections 1.1-1.8 which relate to women with medical as opposed to Obstetric problems	Thank you for this comment and all the comments on specific aspects covered in the guideline

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St.Mary's Hospital, Manchester University Hospital's NHS Trust	Guideline	46	10	For women who have not had a HIV test prior to delivery the guideline suggests only offering testing to those who are considered at an increased risk of carrying the virus. We feel that testing should be offered to all pregnant women, including those later in pregnancy, who have not been tested. We offer HIV testing to all pregnant women. If they have not been tested due to an oversight, or not having had antenatal care, we would offer it at the earliest opportunity even if that is after the baby has been born. If the woman declines testing that is a different matter. It may be they are concerned they have been exposed, but in that case testing is even more important. They will be at a higher risk, if they have the infection it is untreated and so transmission is markedly higher, and interventions that we know reduce the risk of infection can only be undertaken with confirmation of infection. In our trust women who decline testing are seen by the GU medicine team and the reason for declining explored. In some cases we have been prepared to apply for a court order to test the child, but to date this has not been necessary. We would recommend the following. All women should be offered HIV testing, regardless of risk or the stage of pregnancy. This would include immediately after birth. Women who decline should be counselled by a senior clinician and the reasons for declining explored. In particular, we would stress the potential impact on the child and the opportunity to protect them.	Thank you for this comment. We have added to recommendation 1.18.7 to say that all women who have had no antenatal care should be offered serology for HIV, hepatitis B and syphilis. Serology for hepatitis C would not be performed routinely. Results for hepatitis B would help with regard to providing immunisation, but this is not so for hepatitis C

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UK Haemophilia Centre Doctors' Organisation	Evidence review F	21	5to9	There are a large number of bleeding disorders, particularly coagulation factor deficiencies that need different management strategies. Whilst it is written that the Committee searched for evidence.....it was of low quality...small samples size and so on: in practice there will be reference to the RCOG Green-top Guideline No. 71, a joint document written alongside the United Kingdom Haemophilia Doctors Organisation, and it would be highly appropriate to link the 2 documents.	Thank you for this comment. The RCOG Green-top Guideline No. 71 is referenced in a later section of the evidence review but for clarity we have added another reference to it within the section you are referring to (see the section headed other factors the committee took into account, p 22)
UK Haemophilia Centre Doctors' Organisation	Guideline	19	20	"assume the baby will be at risk of bleeding irrespective of the woman's platelet count" – suggest reworded to "recognise that the baby may be at risk of bleeding irrespective of the woman's platelet count"	Thank you for this comment. We have amended the recommendation so that it states "plan as if the baby will be at risk of bleeding irrespective of the woman's platelet count"
UK Haemophilia Centre Doctors' Organisation	Guideline	19	3	The use of the term 'bleeding disorder' is ambiguous and should not be used without further clarification i.e. separate thrombocytopenia from congenital bleeding disorders (factor deficiencies and platelet functional disorders) ; management statements on bleeding risk with regional anaesthesia for congenital bleeding disorders should involve a haematologist working within a haemophilia comprehensive care centre, with planning required for neonate and mother. National UKHCDO guidelines/RCOG green-top guidance should be cross-referenced. The cause of thrombocytopenia needs to be established before delivery with a bleeding history and additional coagulation tests if these haven't been done in discussion with a haematologist.	Thank you for this comment. There are cross-references to the RCOG guideline on management of inherited bleeding disorders in pregnancy (Green-top Guideline No. 71) in evidence review F, which presents in full the committee's discussion of the evidence
UK Haemophilia	Guideline	20	1	Weekly monitoring from 36 weeks seems quite late	Thank you for this comment. The choice of 36 weeks was based on it being 1 week before a term birth which would

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Centre Doctors' Organisation					provide sufficient time for effective treatment to boost platelet count
UK Haemophilia Centre Doctors' Organisation	Guideline	20	16,17	Define/qualify "with caution" – should it involve senior support, for example?	Thank you for this comment. The platelet count in women with immune thrombocytopenic purpura does not reflect the fetal platelet count and therefore all babies should be considered at risk of bleeding. The "caution" in this recommendation is a reminder to the healthcare professional that because of the risk of fetal bleeding, the use of fetal scalp electrodes and mid-cavity or rotational forceps should be carried out with extra care and awareness of this risk. Individual obstetric concerns and other elements of intrapartum fetal wellbeing prevented us from recommending that these procedures should be avoided. We have added more detail to the rationale and impact section to clarify what is meant by "caution" in this context
UK Haemophilia Centre Doctors' Organisation	Guideline	21	Table 2	Repeatedly refers to "IPT" rather than "ITP". Also, is this table purely about ITP thresholds? Not very clear and would be surprised at the 50 threshold in situations other than ITP	Thank you for this comment. We have corrected the abbreviation to read ITP and clarified in the table title that the table relates to the platelet count in women with ITP or gestational thrombocytopenic purpura
UK Haemophilia Centre Doctors' Organisation	Guideline	64	32	Actually ambiguous/ misleading ; need to make distinction between comments on thrombocytopenia and in presence of a functional platelet defect - this is not a feature of ITP. Acquired platelet function defects due to drugs or congenital platelet function	Thank you for this comment, although it is not clear which text you are referring to (there is no line 32 on page 64). We think it may relate to the section beginning on page 64, line 13. We could not find any evidence of a high-enough standard to provide a recommendation for

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				disorders statement is incorrect e.g. Glanzmann's, type 2B VWD bleeding risk is high and can be predicted.	intrapartum management for women with platelet function disorders. We felt that there was enough evidence and experience in the committee with a co-opted obstetric-haematology expert to make recommendations on intrapartum management for women with immune thrombocytopenic purpura according to platelet count
UK Haemophilia Centre Doctors' Organisation	Guideline	65	1	Does it mean autoantibody, rather than alloantibody? The text suggests that the reason that patients with gestational thrombocytopenia do not have problems is because they do not have an alloantibody – this is wrong as it is an autoantibody that is present in ITP.	Thank you for this comment. The draft guideline text is correct as written. Women with gestational thrombocytopaenia do not have an allo-antibody. An allo-antibody is a maternal antibody that crosses the placenta to affect the baby. An allo-antibody causes fetal thrombocytopaenia in approximately 5% of women with immune thrombocytopenic purpura. Fetal thrombocytopaenia does not result from a pregnancy where the woman has gestational thrombocytopaenia
UK Haemophilia Centre Doctors' Organisation	Guideline	9	14	Comment from one member: -if the risk of bleeding is assessed as high it is important that therapeutic LMWH is not introduced too quickly, and stepwise re-introduction escalating back to therapeutic doses according to bleeding risk should be recommended. Comment from another member: The section on post partum re-introduction of full anticoagulation post delivery in women with valves states – to have review at 3-4 hours then consider..	Thank you for this comment. With regard to the first part of the comment, this is a tricky clinical situation, in which there is a need to balance an individual woman's differing risk of uterine bleeding with the risk of maternal mechanical heart valve thrombosis. We provide three therapeutic options for the senior clinical review team to choose between using their clinical judgement of the specific situation. With regard to the second part of the comment, the care of the woman in this situation is a balance between the risk of bleeding and the risk of thrombosis, and we would

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				One of the options is full dose anticoagulation at that point. In practice this may not be a very good idea especially as major bleeding at this stage will result in much more prolonged withholding of anticoagulation and so an increased thrombosis risk rather than a decreased one. It is felt that on the first day post partum the maximum to be considered is LMWH prophylaxis, with escalation to full dose to be made 24 hrs post partum/thereafter.	consider the risk of thrombosis and death of the woman a greater risk, and therefore agree it is reasonable to offer therapeutic low-molecular-weight heparin earlier to women with, for example, 2 or more mechanical heart valves, especially if these are in the right side of the heart. The final part of the comment reflects an opinion from a single individual, and having made recommendations taking account of evidence presented and informal consensus of the committee we do not think it is appropriate to change the recommendation to reflect this differing opinion
UK Haemophilia Centre Doctors' Organisation	Guideline	General comment	General	In the section on Bleeding Disorders there is little reference to the management of the baby; in contrast in the section on ITP there is reference to the baby having a risk of thrombocytopenia and bleeding. It is suggested that there should be an addition to advise a written perinatal plan, agreed by haematology, that is fully Observed by all multidisciplinary team members; if there is no perinatal management plan available (with haematological input), then the adult haematologist should be contacted for a plan, and the cord blood should be checked for FBC prior to discharge if the mother has ITP; advice should be obtained to consider testing of the baby for the mother's bleeding disorder.	Thank you for this comment. We considered gestational thrombocytopenia and immune thrombocytopenic purpura (meaning immune destruction of platelets leading to thrombocytopaenia and purpura) to be the haemostatic disorders of most relevance in this guideline because these are the two most commonly encountered bleeding disorders in clinical practice. Our view is that it is important to exclude other serious pregnancy-related thrombocytopenia such as pre-eclampsia or antiphospholipid syndrome. Recommendation 1.6.5 notes that the platelet count should be measured in the umbilical cord at birth. Also, we recommend that a haematologist is included in the multidisciplinary team which we think addresses the issue of where there is no perinatal management plan available

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UK Haemophilia Centre Doctors' Organisation	Guideline	General comment	General	The section on Bleeding Disorders is minimal: ultimately would be dependent on the fact that all the right decisions had already been made earlier in delivery – there seems no mention of knowing what factor levels are or if that has even been considered.	Thank you for this comment. We were aware that RCOG Green-top guidelines on pregnant women with inherited bleeding disorders were being developed (Management of Inherited Bleeding Disorders in Pregnancy; Green-top Guideline No. 71). We also considered that if all the conditions with thrombocytopenia were to be included, the treatment of associated medical problems could be undermined by someone who was looking at this guideline only. For example, with HELLP syndrome, clinicians might focus only on low platelet count and pay less attention to treating pre-eclampsia. Therefore, we considered gestational thrombocytopenia and immune thrombocytopenic purpura (meaning immune destruction of platelets leading to thrombocytopaenia and purpura) to be the haemostatic disorders of most relevance in this guideline because these are the two most commonly encountered bleeding disorders in clinical practice

Registered stakeholders