Caesarean birth maternal request

Consultation on draft guideline - Stakeholder comments table
02/05/23 – 15/05/23

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Stakeholder	Document	Line No	Comments	Developer's response
Association for Improvements in the Maternity Services	General		AIMS is generally supportive of the amended guidelines and hopes it is clear that people will not be required to have continuous discussions with various healthcare professionals around their decision.	Thank you for your comment and support of these amendments. The recommendations state 'If, after an informed discussion about the options for birth…the woman or pregnant person requests a caesarean birth support their choice.' We hope this makes it clear that the decision made by a woman or pregnant person should not be repeatedly questioned.
Association for Improvements in the Maternity Services	General		AIMS suggests including a reference to when the request is made in labour, recognising that although the situation may be challenging, the same principles of informed choice should apply.	Thank you for your comment. The committee agreed that a request for a caesarean birth made during labour would be discussed with the woman or pregnant person and an individualised decision would be made in conjunction with the person based on their wishes but also the clinical situation (for example late in the second stage it may not be advisable if the baby is too far down the birth canal). The committee agreed that this discussion would not be any different from any other clinical discussions and decisions that need to be made with the woman or pregnant person during labour and so did not add this specifically to the recommendations about maternal request caesarean birth, which relates to an antenatal request for caesarean birth.

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Association for Improvements in the Maternity Services	Table	001	**1.2.25** AIMS supports this recommendation to be offered a conversation with consultant midwife/obstetrician//anaesthetist to reduce the times a person feels they need to justify their decision. We recommend altering the wording to recognise that other senior members of staff may be involved in informed decision making conversations. Staff should recognise that people often enter these discussions expecting to have to "fight" for their choice. It should be emphasised that this is not necessary and efforts are made to help the pregnant person feel empowered and respected.	Thank you for your comment. The recommendations already state that discussions about maternal request caesarean birth should be undertaken by midwives, obstetricians, anaesthetists and healthcare professionals with expertise in perinatal mental health support, as appropriate so involvement of a range of senior healthcare professionals is already recommended. The guideline now states 'If, after an informed discussion about the options for birth…the woman or pregnant person requests a caesarean birth support their choice.' We think this makes it clear that the choice of the woman or pregnant person is paramount.
Association for Improvements in the Maternity Services	Table	001	**1.2.25** (Impact of change). We are concerned to see the emphasis on vaginal birth, as this seems to imply that one mode of birth is superior to another. Staff must recognise that the pregnant person is the best person to know what's right for them.	Thank you for your comment. There is no suggestion in the recommendations that one option is better than the other. The impact statement has however been amended to state that this discussion and support may lead to more women and pregnant people having the birth mode that is preferred by them.
Association for Improvements in the Maternity Services	Table	006	**1.2.30** AIMS supports this recommendation to ensure services are offered within the same Trust or hospital.	Thank you for your comment and support for this recommendation.

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Birth Trauma Association	Table	001	**1.2.25** Strongly disagree with this statement: "This change may mean more women and pregnant people can be supported to have a vaginal birth." **The aim of discussions should be to support women to make the right decision for their own physical and mental health. Whether the number of vaginal births increase is irrelevant.** This is most likely achieved when a woman feels she is in control of decision-making and is supported in her choice. Many women who choose caesarean and are regarded as 'maternal choice' in fact sit at the margins of risk. They are often older first-time mums, those who have had a prior traumatic birth or have significant fear of childbirth. They consider they are at risk of a complex vaginal birth and in most cases that is a reasonable judgement. Unfortunately, the caesarean risk factors provided by NICE looks at population data and does not take account of these risks so the quality of information being given to these women can be poor. They should not feel badgered into choices they do not want or have to jump through multiple hoops to have their choices respected. It is equally important that women who want support to overcome fear of childbirth should be supported. However, these two very different groups of women with	Thank you for your comment. The recommendation advises that women and pregnant people are offered support to help address concerns about the birth – for example a woman or pregnant person requesting a caesarean birth because they fear the pain associated with a vaginal birth may be reassured that there are a number of effective pain relief options that can be used to manage their pain, and therefore decide that a vaginal birth may be an option they wish to reconsider. There is no suggestion in the recommendations that one option is better than the other. The impact statement has however been amended to state that this discussion and support may lead to more women and pregnant people being fully supported in their chosen mode of birth. There is also an additional recommendation that advises that once a woman or pregnant person has requested a caesarean birth that choice should be supported. The recommendations do, as you suggest, offer support for women or pregnant people who want help to overcome the fear of childbirth and to support those who may have very valid reasons for choosing a caesarean birth. The recommendations on discussing benefits and risks of caesarean birth are already included in

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			very different motives for choosing caesarean should not be conflated and have the same care pathway. 1.2.25 When a woman or pregnant person with no medical indication for a caesarean birth requests a caesarean birth: • discuss and explore the reasons for the request • ensure health care professionals providing the information can provide accurate information based on their individualised risk factors • where the mother is agreeable discuss alternative birth options (for example, place of birth, continuity of midwifery care, pain relief options), which may help address concerns they have about the birth • offer discussions with a consultant midwife or senior midwife, ideally in a birth options clinic or at a birth options appointment • offer discussions with a consultant or senior obstetrician and other members of the team (for example an anaesthetist) if the woman feels this is appropriate. • record the discussions and decisions. [2011, amended 2023] Women who want help to overcome their fear of childbirth should obviously be supported but women who have a firm desire for a maternal choice caesarean section should not be forced	the guideline in the section called 'Benefits and risks of caesarean birth' and this includes consideration of individual risks so this has not be included again in this recommendation. The wording of the recommendation has however been amended to clarify that discussions should always be offered to women and pregnant people (meaning that they can decline them if that is their wish).

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British Maternal and Fetal Medicine Society	General		Women need to be given written or digital information including a consent form and time to consider the decision and be aware of the risks of the procedure. It would be ideal that this information were specific to women who are requesting caesarean section.	Thank you for your comment. We agree that women and pregnant people need to be given information in an appropriate format and consented, and this detail is already included in the separate sections of the caesarean birth guideline called 'provision of information' and 'shared decision making'.
British Maternal and Fetal Medicine Society	General		The timing of birth, if only for maternal request should be at 39 weeks.	Thank you for your comment. We agree that a planned caesarean birth should be at or after 39 weeks, and this detail is already included in the separate section of the caesarean birth guideline called 'timing of planned caesarean birth'.
Caesarean birth	EIA	3.4	Re: Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group? The recommendations have been amended to reduce potential difficulty with access for selected groups. My organisation does not believe the amended recommendations go far enough to improve equality. The whole premise of	Thank you for your comment. The editorial changes to these recommendations were prioritised for update to reduce the inequalities that have been described in the EIA form, and ensuring that women and pregnant people do not have to move obstetric units will have addressed many of the issues that were previously of concern. Furthermore, the simplification of the recommendations about providing caesarean birth as an option in all obstetric units should reduce this even further. People not knowing about the existence of NICE guidelines is not something that updating the guidance itself can address but this comment will be passed to the NICE team to be

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			offering planned caesarean birth only to those who request it means there is still potential difficulty with access for selected groups. For example, many women may not know that requesting a caesarean birth is an option; they may not be aware that NICE recommendations exist (especially if they have recently moved to the UK and/or English is not their first language), or that they should be referred to an obstetrician who is willing to support them if their initial request is refused (and the latter certainly happens). Recent research* from Canada reported that three covariates associated with caesarean birth choice included "late maternal age (≥ 35 yr), being White, living in a neighbourhood of a higher educational quintiles". The others were: "gaining more than the recommended weight in pregnancy, nulliparity, conception by in vitro fertilization, anxiety, not attending prenatal classes, delivering at a hospital that provides	considered where relevant support activity is being planned. The impact statement has been amended to state that discussion and support may lead to more women and pregnant people having the birth mode that is preferred by them (rather than more women and pregnant people being supported to have a vaginal birth). The guideline makes it clear that women and pregnant people have the right to choose their mode of birth and that this choice should be supported.

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			maternal level IIc or III care and receiving antenatal care from obstetricians". *(2021) Birth outcomes following cesarean delivery on maternal request: a population-based cohort study https://www.cmaj.ca/content/193/18/E634 It should not be the case that different women have different or better access to different information and/or options. This is not equality. That this proposed update includes a rationale aimed at ensuring more women "can be supported to have a vaginal birth" is a perfect example of how social determinants of health may be perpetuated. Providing information that is deliberately biased towards achieving higher numbers of vaginal birth is no better than denying caesarean birth choice, and women with lower levels of education and/or living in lower socio economic areas are most likely to be affected.	

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			What's worse is that if they (or their baby) do experience injury or trauma giving birth vaginally (or with an emergency caesarean), when their preference was a planned caesarean, they may not have the means to support their immediate and/or long-term needs. They may also find it more challenging to navigate litigation, if it comes to that. Again, both birth mode plans have risks, but women have to be free to decide for themselves, without bias or coercion, as noted in the SOGC's 2018 recommendations on this topic.	
Caesarean birth	EIA	3.5	Re: No, there is not potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability? If this remains, please replace question mark with a period.	Thank you for your comment. This question mark has been replaced with a full-stop.

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Caesarean birth	General		The comments here use the terms woman and women, and should be taken to include people who do not identify as women but are pregnant or have given birth.	Thank you for this clarification about your comments.
Caesarean birth	General		Thank you for this opportunity to comment; it is very much appreciated.	Thank you for taking the time to comment.
Caesarean Birth	Guideline	Intro	Re: Covers when to offer caesarean birth, discussion of caesarean birth, procedural aspects of the operation, and care after caesarean birth. It aims to improve the consistency and quality of care for women who are thinking about having a caesarean birth or have had a previous caesarean birth and are pregnant again. NICE moved ahead of so many organisations on the issue of caesarean birth choice (at least since 2010/ 2011), but this proposed update is not at all what was expected for going forward, and my organisation has serious concerns about a number of the changes outlined, and the rationale behind them.	Thank you for your comment. The introductory text you are referring to applies to the whole guideline on caesarean birth, and not just the section on maternal request which has been included in this small editorial update. The complete guideline does provide guidance on planning mode of birth with consideration of the risks and benefits of both caesarean and vaginal birth. It is not within the remit of NICE to consider or advise on practices in private healthcare settings, but these recommendations for the NHS aim to ensure that women or pregnant people receiving maternity care in the NHS do have the option of requesting a caesarean birth. Thank you for informing us about the Plan-A research study. We will pass this information to

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			The update says it covers "when" a caesarean birth should be covered; yet NICE could have stated instead: "Planned caesarean birth should always be offered, alongside planned vaginal birth." This would best improve the consistency and quality of care for women who are thinking about having a caesarean birth or have had a previous caesarean birth and are pregnant again. Also, this is precisely what happens in private maternity care (and has done for many decades), and health professionals in private clinics (including both midwives and obstetricians) have access to the same research data and evidence as those working in the NHS. It should not be the case that women giving birth in the NHS continue to be offered vaginal birth and midwife-led care only as a default, unless they 'request' otherwise. The National Institute for Health and Care Research recently awarded one million pounds in funding for a "Plan-A" research	the NICE surveillance team which monitor key events relevant to the guideline. The terminology 'maternal request' is simply a heading used to differentiate these recommendations from those situations where women or pregnant people are advised by their healthcare professionals that, despite the fact they may be hoping for a vaginal birth, a caesarean birth may be the appropriate and safest mode of birth for them. However, we agree that the wording 'maternal choice' may be more appropriate than 'maternal request' and so have amended the heading to state this. As already stated, the recommendations that have been updated, do aim to ensure that women or pregnant people receiving maternity care in the NHS have the option of either a vaginal birth or a caesarean birth. NICE is reviewing the provision of its guideline portfolio with the intention to moving to a system of digital living guidelines which encompass pathways of care, rather than individual guidelines but this is a longer-term aim.

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			study led by the University of Aberdeen (Caesarean Birth is a PPI member), and in its press release, the NIHR cites NICE guidance: October 6, 2022: New trial launched to help women make childbirth choices https://www.nihr.ac.uk/news/new-trial-launched-to-help-women-make-childbirth-choices/31634 "Researchers aim to develop a 'decision aid' that will help pregnant women to make an informed choice between vaginal or caesarean birth. "In the last decade, national guidance from the National Institute of Health and Care Excellence has stated that the risks and benefits of both vaginal and caesarean birth should be discussed with women during pregnancy to help plan their birth." The lead PI, Dr Mairead Black, said: "This is an important piece of work because it addresses a substantial gap in routine antenatal care in the UK at present. …we will develop a tool to help women decide	

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			between planning a vaginal or caesarean birth in routine antenatal care. My organisation understands that 'caesarean choice' has needed to be categorised under the heading of "maternal request" for many years, but it does not need to stay this way, and NICE is in a powerful position to change it. There are no 'request' headings within NICE guidance for other birth plans where risks and benefits need to weighed (e.g. home birth request, water birth request, VBAC request, midwife-led care request), since they are considered a standard of care to be offered to all women. Eight years on from Montgomery, NICE could be at the forefront of a national initiative to implement change so that all birth mode and place plans are communicated and available to all women. My organisation also continues to request that NICE guidelines are no longer separated, so that caesarean birth	

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			information becomes an integral part of 'antenatal care', for example. There are some NHS trusts already moving ahead of the curve, with a more balanced approach to communicating all choice plans, including caesarean birth, and for reference, one example of this is Whittington Health NHS Trust. Unfortunately, the opposite is true in other trusts, which is why NICE's wording here is so critical.	
Caesarean birth	Guideline	Intro	Re: Revised recommendations on maternal choice My organisation prefers this wording to request, thank you.	Thank you for your comment. The heading for this section of the guideline has been changed to 'maternal choice'.
Caesarean birth	Table	1	Re: ensure they have accurate information There is disagreement even among health professionals as to what constitutes 'accurate' information about different planned birth modes, and individualised care is essential. My organisation recalls the	Thank you for your comment. 'Balanced' has been added here as you requested.

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			language used in the NICE podcast that followed its publication of CG132 recommendations in 2011, during which the guideline chair made references to women who may have been "misinformed" or "misunderstood". If NICE keeps 'accurate' here, can it please revise to: "accurate and balanced information"	
Caesarean birth	Table	1	Re: discuss alternative birth options (for example, place of birth, continuity of midwifery care, pain relief options), which may help address concerns they have about the birth Most women already know about these options, and it would be interesting to understand NICE's rationale for including "place of birth" here? What was the evidence used to suggest women requesting a caesarean birth either do not know that planning a home birth is an option, or are likely to change their birth plan once this option is discussed?	Thank you for your comment. This was an editorial update so the committee did not review evidence but agreed that concerns about the birth process may relate to women or pregnant people's fear of having a long labour in an unfamiliar and clinical hospital environment and that ensuring they knew about the options for birthing centres or home birth may, in some cases, alleviate these concerns. Midwifery Continuity of Care has been rolled out across England and should be the default model of care since March 2023, but there is not the same mandate for continuity of obstetric care so the committee were unable to recommend this. However, the recommendations have been amended to clarify that discussions should be

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			It is important to note that continuity of obstetrician-led care is just as valuable and sought after by most women who are considering choosing a caesarean birth, and in terms of practical resources (i.e. the reported shortage of midwives), my organisation would like to communicate feedback it has received from women who often feel frustrated having to repeat their reasons for wanting a caesarean to numerous midwives, and having to wait weeks or even months to see an obstetrician. Even then, they may not see the same obstetrician a second time, and can often receive different information and/or levels of support from different health professionals (including from two obstetricians). This guideline update does not adequately address this issue. Lastly, it is ironic and unfair that NICE recommends discussing and offering continuity of midwifery care to women if they choose a vaginal birth plan, but not offering any (let alone continuity of) obstetrician care	available with an obstetrician if requested by the woman or pregnant person, and that once a decision has been made by the woman or pregnant person that they wish to have a caesarean birth that decision must be recorded and supported, so multiple discussions should not be needed.

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			as standard to those who are certain, early in their pregnancy, that they want to choose a caesarean birth plan. These discussions are only deemed available "if necessary".	
Caesarean birth	Table	1	Re: offer discussions with a consultant midwife or senior midwife, ideally in a birth options clinic or at a birth options appointment Why is there no mention of an obstetrician here, as standard? In my organisation's experience, most women who are thinking about having a caesarean birth have more questions for an obstetrician than a midwife (for example, more detailed questions related to surgery). They are also very keen to have their caesarean birth choice agreed early on in pregnancy, instead of having to wait weeks and months before receiving confirmation from an obstetrician. In situations where an obstetrician is not going to agree and support their caesarean birth choice, they want to know sooner rather than later.	Thank you for your comment. The committee advised that with the increase in the number of consultant midwives the availability of birth options clinics or birth options appointments are becoming more common. The committee agreed that an obstetrician should always be available to be involved in such discussions if necessary but have amended this recommendation to clarify that this should also be if requested by the woman or pregnant person. The decision to suggest that the majority of detailed discussions could at least be initiated by a senior or consultant midwife was based on a concern for the resource implications of mandating that every woman or pregnant person must be seen by an obstetrician. The committee agreed that practice in the NHS is no longer focussed on keeping caesarean rates below a certain level, and as stated above the offer of a discussion with an obstetrician is now recommended for all women or pregnant people.

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			Additionally, there is evidence from CQC inspection reports that NHS hospital trusts can use birth options clinics as a way to dissuade women from choosing a caesarean birth, often to keep their caesarean rates down, and there is a risk that information may not be communicated in a balanced or unbiased way. My organisation is not against these discussions with midwives or within options clinics, but they should be offered alongside the offer of discussion with an obstetrician too.	
Caesarean birth	Table	1	Re (rationale): there may be cases where the concerns can be addressed in other ways, such as choosing an alternative place of birth, opting for a birth which will provide greater continuity of midwifery care The committee is in danger of insulting the intelligence of women in the way that it has expanded this definition, and the additional points are noticeably focused on treating caesarean birth choice as a problem that needs to be addressed or fixed. Trying to	Thank you for your comment. There is no suggestion in the recommendations or the rationale that caesarean birth is a problem that needs to be fixed, but the committee were aware of situations where women or pregnant people had concerns about the birth process which they thought could only be addressed by having a caesarean birth, and that this may not always be the case, with some women and pregnant people feeling reassured that a vaginal birth may be an option for them after all. The recommendations in this section of the guideline make it clear that a caesarean birth is an option for all women and pregnant people who wish it, and that obstetric

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			change the plan to a vaginal birth, as opposed to (for example) ensuring that the risks of surgery, plans for family size (due to increased risks with multiple surgeries) and the availability of post-surgery support at home are all fully discussed too. This proposed change may weaken the recommendation in settings where caesarean birth choice is not supported. If time is an issue for obstetricians, then there needs to be change within the NHS to ensure that women have access to an obstetrician as readily as they do a midwife. NICE could recommend this.	units cannot opt out of supporting this choice. The wording in the impact section has been changed to reflect the fact that women and pregnant people are being supported to have their preferred mode of birth. Time is not an issue that has influenced the development of these recommendations but the committee agreed that the most appropriate person to initiate discussions about maternal choice caesarean birth was a consultant midwife or senior midwife, but that women and pregnant people could speak with an obstetrician if they wished.
Caesarean birth	Table	1	Re (rationale): This change may mean more women and pregnant people can be supported to have a vaginal birth. This rationale is a shocking and disappointing development from NICE, demonstrating unacceptable and unexpected bias towards one mode of birth plan over another. Given Montgomery,	Thank you for your comment. There was no intention when making the recommendations to imply that one mode of birth is better than the other. The impact statement has however been amended to state that this discussion and support may lead to more women and pregnant people being fully supported in their chosen mode of birth.

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			Ockenden review findings, and unprecedented litigation claims values in maternity services, this new rationale from NICE is deeply concerning, yet perfectly illustrates why the proposed update is worse than the 2021 wording. The idea that planned vaginal birth is somehow better, preferred or superior to planned caesarean birth persists in the minds of some health professionals, and this is the reality in which many women are making their caesarean birth request. This means NICE recommendations need to be even stronger to ensure their request is better understood, respected and supported; not moving in the opposite direction. This article by associate lawyer Lindsay McGivern refers to guidance published by the Society of Obstetricians and Gynecologists of Canada (SOGC) in 2018 that is relevant to this point. Summer 2019 Issue 161: Informed Consent in the Obstetrical Context: Do Women have a Right to Caesarean Section?	

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			https://www.pacificmedicallaw.ca/blog/publications/informed-consent-in-the-obstetrical-context-do-women-have-a-right-to-caesarean-section/ "So long as a patient has capacity, he or she must give consent (**free from coercion or undue influence**) to any medical treatment before it can be provided. "The mode of delivery is not to be imposed by a physician. The patient must agree with the planned method of delivery **without bias or coercion**. Physicians are not obligated to perform a caesarean section if they are not comfortable (for medical, ethical or other reasons) with the decision to proceed with this method of delivery. If a patient requests a caesarean section, however, the physician must either perform it, refer the patient for a second opinion or transfer her care to another physician. Physicians may not simply refuse to perform a caesarean section and force the patient to have a vaginal delivery…" The article below is based on research and women's experiences in Canada, but	

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			reflects what is happening in the UK too, and therefore relevant here. June 24, 2021 Requests for caesarean birth brushed aside, despite guidelines to respect maternal choices https://theconversation.com/requests-for-caesarean-birth-brushed-aside-despite-guidelines-to-respect-maternal-choices-162310	
Caesarean birth	Table	1	Re: offer discussions with a consultant or senior obstetrician and other members of the team (for example an anaesthetist) if necessary Why only "if necessary", and what constitutes "necessary" (both in NICE's view, and more importantly, in the views of healthcare professionals who have the power to decide if a woman is allowed access to an obstetrician (it does not need to be a senior obstetrician)? In what circumstances does NICE consider it 'unnecessary' for a woman to meet with	Thank you for your comment. The committee agreed that an obstetrician should always be available to be involved in such discussions if necessary but have amended this recommendation to clarify that this should also be if requested by the woman or pregnant person. The decision to suggest that the majority of detailed discussions could at least be initiated by a senior or consultant midwife was based on a concern for the resource implications of mandating that every woman or pregnant person must be seen by an obstetrician.

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			an obstetrician in a timely manner if she is planning a caesarean birth?	
Caesarean birth	Table	2	Re: discuss the overall benefits and risks of caesarean birth compared with vaginal birth Please change to: "discuss the overall benefits and risks of planned caesarean birth compared with planned vaginal birth". Otherwise the discussion might compare mixed caesarean birth data with vaginal birth outcomes only, and not properly explain the concept of intention to treat (using lay language). Please see this recent article in The Conversation as an example of how this remains a problem, and the two comments posted beneath: May 2, 2023: Four things you need to know about having a caesarean section https://theconversation.com/four-things-you-need-to-know-about-having-a-caesarean-section-204090 Comment 1 cites NICE NG193:	Thank you for your comment. Although data on planned caesarean birth and planned vaginal birth would be ideal it is not widely available. The section of the caesarean birth guideline on planning mode of birth referred to from this recommendation therefore does not always use data from planned caesarean birth and planned vaginal birth (this is explained fully in appendix A) and so the word 'planned' has not been added to this recommendation. However, we agree that more research is needed on the comparison of planned modes of birth to provide more accurate information for women and pregnant people, and a research recommendation was made highlighting this when the 'planning mode of birth' section of the guideline was updated in 2021. The recommendation about referral to another healthcare professional has been simplified to state that maternal request caesarean birth must be offered in all obstetric units.

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Stakeholder	Document	Line No	Comments	Developer's response
			"The inclusion of caesarean birth choice in articles about birth preferences and options is wonderful to see (thank you), but readers really need to understand that this article cites research papers relating to all caesarean birth outcomes, including emergency surgery following a vaginal birth plan, and surgery planned for medical reasons. When a woman is considering choosing a caesarean birth, she needs information about the potential risks, benefits, and reported outcomes of 'planned' vaginal birth versus 'planned' caesarean birth. Simply comparing all caesarean birth outcomes with all vaginal birth outcomes, even just for some risks and benefits, is unhelpful. In fairness, more research is needed on caesarean birth choice outcomes, but the evidence that is available can be communicated more clearly, with differences explained. This is equally important during antenatal discussions in the NHS maternity services.	

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			To highlight just some of the examples given in this article, with caesarean birth choice there is no increased risk of lacerations, breathing problems, or infertility in subsequent pregnancies, and in fact, in the context of stillbirth, some researchers have reported a lower risk with planned caesarean birth at 39 weeks' gestation when compared to planned vaginal birth. Interestingly, many women list safety (of baby and self) as their reason for choosing a caesarean birth, and yet it is most often 'fear, previous trauma, and control or timing' that are reported. Lastly, it is important to emphasise that for many women, 'the best support, tailored to their needs' (as described in the article's final paragraph), is to receive early confirmation, following an individualised discussion of risks and benefits, that their caesarean birth decision will be respected, and a date for surgery scheduled. The UK's NICE Caesarean birth guideline (NG193, 2021) recommends offering other support	

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			too (e.g. counselling), but women are free to accept or decline this, and offers should not be presented as a condition of their caesarean birth plan. Thank you again, and I agree completely with your advice for women to voice their preferences at the earliest opportunity in pregnancy. NICE recommends, "If a woman requests a caesarean birth but her current healthcare team are unwilling to offer this, refer the woman to an obstetrician willing to perform a caesarean birth." However, if this is a woman's experience, it is best to find out early in pregnancy so that there is ample time to move through the referral process."	
Caesarean birth	Table	5	Re: mental health support access This should specify that it is only for the women referred to in 1.2.27 (line 4), and not all women requesting a caesarean birth. It is very important that neither NICE nor healthcare professionals in the NHS assume that all women requesting a	Thank you for your comment. This recommendation states that it relates to women and pregnant people receiving perinatal mental health support but it has been clarified that this is for tokophobia or other severe anxiety about childbirth.

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			caesarean birth are seeking or require 'help in overcoming fears and concerns about the labour and birth'. There are well documented risks and benefits with both birth mode plans, and it is not unreasonable, irrational or necessarily fear-based for a woman to plan a caesarean birth if she has decided that a caesarean birth is the safest choice for her and/or her baby.	
Caesarean birth	Table	6	Re: If, after an informed discussion about the options for birth (including perinatal mental health support if appropriate; see recommendation 1.2.27), the woman or pregnant person requests a caesarean birth support their choice. The existing wording was sound, apart from not saying "**planned** vaginal birth" instead of "vaginal birth". In fact the 2021 wording of this recommendation makes it clearer that perinatal mental health support should only be offered, and is not a condition of	Thank you for your comment. The committee agreed that it was more person-centred language to suggest that if a woman or pregnant person requested a caesarean birth her choice should be supported. This recommendation does not use the term 'vaginal birth' so we have not been able to consider amending to 'planned vaginal birth'. However, the recommendation has been amended as you suggest to refer to the offer of perinatal mental health support, as not all women and pregnant people will accept this offer.

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			ensuring caesarean birth support. Again, it is very important that this is emphasised here. Suggested change: "If, after an informed discussion about the options for birth **plans** (including **the offer of** perinatal mental health support, if appropriate; see recommendation 1.2.27)…"	
Caesarean birth	Table	6	Re: requests a caesarean birth support their choice Please insert a comma after 'caesarean birth': "requests a caesarean birth, support their choice"	Thank you for your comment. This comma has been added.
Caesarean birth	Table	7	Re: 1.2.30 If a woman or pregnant person requests a caesarean birth but their current healthcare team are unwilling to offer this, refer them to an obstetrician willing to perform a caesarean birth. This should be within the same obstetric unit. The detail about the same obstetric unit is an excellent addition, thank you.	Thank you for your comment. Based on feedback from other stakeholders this recommendation has been simplified to state that a caesarean birth should be offered in their obstetric unit.

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Caesarean birth	Table	7	Re: but their current healthcare team are unwilling to offer this Please change to: "but their current healthcare team **is** unwilling to offer this	Thank you for your comment. Based on feedback from other stakeholders this recommendation has been simplified to state that a caesarean birth should be offered to women or pregnant people in their obstetric unit.
Healthcare Safety Investigation Branch	Table	001	HSIB investigations have identified that a number of Trusts do not have written guidance or pathways to support staff with recommended actions when a woman or pregnant person requests a caesarean birth with no medical indication. HSIB would welcome guidance from NICE that all trusts should have clear **written** pathways for women requesting caesarean birth with no clear medical indication.	Thank you for your comment. NICE has provided advice on the action to be taken when a woman or pregnant person requests a caesarean birth, but it is not in NICE's remit to provide specific details of how individual trusts should implement these recommendations, such as writing local pathways.
Healthcare Safety Investigation Branch	Table	001	HSIB has found that when a woman/pregnant person requests a caesarean birth for no clear medical indication during the intrapartum (rather than the antenatal period), trust pathways are not always clear in guiding staff with recommended actions. HSIB would welcome guidance form NICE that pathways should include recommendations for staff for requests for caesarean birth that are made throughout the pregnancy pathway.	Thank you for your comment. The committee agreed that a request for a caesarean birth made during labour would be discussed with the woman or pregnant person and an individualised decision would be made in conjunction with her based on her wishes but also the clinical situation (for example late in the second stage it may not be advisable if the baby is too far down the birth canal). The committee agreed that this discussion would not be any different from any other clinical discussions and decisions that need to be made with the woman or pregnant person during labour and so did not add this specifically to the

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				recommendations about maternal request caesarean birth, which relates to an antenatal request for caesarean birth.
Healthcare Safety Investigation Branch	Table	002	HSIB investigations have identified uncertainty amongst staff about the recommended action when a woman/pregnant person, who was planning a caesarean birth for maternal request, attends the maternity unit in labour. HSIB would welcome recommendations from NICE for trusts' guidance to include recommended actions for their staff in this situation.	Thank you for your comment. If a woman or pregnant person has already started in labour then the decision about whether it is possible to proceed with the caesarean birth would be an individualised decision based on the labour ward activity and the stage of her labour. As this would be an individualised decision the committee agreed that it would not be possible to make useful recommendations on the action to be taken in each situation.
Healthcare Safety Investigation Branch	Table	002	HSIB investigations have identified that on occasion, when women who have planned a caesarean for maternal request attend the maternity unit in labour prior to their caesarean date, the acuity of the unit is such that the caesarean birth cannot be accommodated at that time. HSIB would welcome recommendations from NICE for trusts' guidance to include information sharing with families on procedural aspects which include a small chance of having to delay caesareans due to unavoidable acuity.	Thank you for your comment. The committee agreed that it was standard practice to inform the woman or pregnant person that whilst every effort is made to comply with her wish to proceed with a caesarean if they attend in labour, there are some circumstances where this might not be possible, for example if they attend in labour and there are more urgent caesareans (with risk to mother or baby) that need to be carried out.

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London Neonatal Operational Delivery Network	General		In my experience, there is an increased likelihood of the timing of maternal request CS to be before 39 weeks gestation. Should there be a specific point made in this guideline around the importance of sticking to the 39 week guidance around timing of elective CS? This could include specific advice to inform the woman of the risk of increased respiratory morbidity in the baby of CS before 39 weeks.	Thank you for your comment. We agree that a planned caesarean birth should be at or after 39 weeks, and this detail is already included in the separate section of the caesarean birth guideline called 'timing of planned caesarean birth', which also already includes advice that this timing is to reduce the risk of respiratory morbidity.
London Neonatal Operational Delivery Network	Table	001	I agree that "alternative birth options" should be discussed. However, I am aware that some birth options are not available everywhere eg continuity of carer, particularly for low risk pregnancies. So I think this point needs to include a caveat, such as "where available", so as to avoid 'over-promising' and potential conflict.	Thank you for your comment. Midwifery Continuity of Care has been rolled out across England and should be the default model of care since March 2023, but we recognise that there are some areas where safe staffing levels may not allow for this to be fully implemented so have added 'where available' as you suggest.
London Neonatal Operational Delivery Network	Table	007	I think the recommendation should include a recognition that, as discussed in 'Rationale for change' column, there may be circumstances where it may not be possible to provide an obstetrician willing to perform a CS, due to clinical circumstances.	Thank you for your comment. The committee agreed that this was such a rare occurrence that it would weaken the recommendation to suggest clinical reasons could be used to 'deny' maternal request caesarean births and so did not include this in their recommendations.
National Childbirth Trust (NCT)	Table	001	A good update. We also suggest it might be helpful for some service users (women with perinatal mental health concerns, women from	Thank you for your comment and support for this update. The guideline does not suggest where the discussions should take place, but if

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			lower socioeconomic groups, women uncomfortable in institutional settings) if consideration was given to whether their home or a neutral setting would be the best place for the discussion. Cost implication for staff to travel to an out-of-hospital location.	arrangements had been made for a woman or pregnant person to receive antenatal care outside usual settings then the birth options discussion could take place in this setting as well, where possible. However, as you note this may have cost implications and so the committee did not specifically recommend this as an option.
National Childbirth Trust (NCT)	Table	001	It may be helpful to clarify that the woman can be accompanied by a person of her choice, and that interpretation services must be provided where needed. No cost implication as this should already be provided.	Thank you for your comment. We agree that women and pregnant people need to be given information in an appropriate format that can be understood, and that people can choose to involve family members and carers, but this is included in the NICE guideline on Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, and so this information is not repeated in all other NICE guidelines.
National Childbirth Trust (NCT)	Table	001	It could also be helpful to gather anonymous data about women's reasons to inform future staff learning, i.e. the impact of a prior traumatic birth. Administrative need.	Thank you for this comment. Your comments relating to data gathering will be considered by NICE where relevant support activity is being planned.
National Childbirth Trust (NCT)	Table	006	This implies that the staff will only support the woman's choice if she has participated in discussion. It should be clear that this is not a hoop to be jumped through. If the woman	Thank you for your comment. In order to perform a caesarean birth the woman or pregnant person will need to provide informed consent and so there will need to be some discussion of the risks and benefits of a caesarean birth. However the

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			declines to discuss her decision it should still be respected.	recommendation makes it clear that the woman or pregnant person's choice should be supported.
National Childbirth Trust (NCT)	Table	007	A good update.	Thank you for your comment and support of this update.
NHS England	EHIA	General	We strongly suggest given the evidence surrounding the risk of racial bias surrounding these decisions, this needs to be factored into decision making and should be considered as part of the EHIA.	Thank you for your comment. As this was an editorial update without an evidence review the committee did not have evidence of racial bias relating specifically to maternal request caesarean birth. However the committee were aware of the less favourable maternity outcomes for women and babies from some racial groups as reported in the MBRRACE-UK report and so have included this in the EIA form.
NHS England	Table	General	Where there is reference to communication and information within the table, we recommend including reference to the importance of Communication: Communicate with and try to understand the person you are caring for. Check with the person themselves, their family member or carer or their hospital or communication passport for the best way to achieve this. Use simple, clear language, avoiding medical terms and 'jargon' wherever possible. Some people may be non-verbal and unable to tell you how they feel. Pictures may be a useful way of communicating with some people, but not all.	Thank you for your comment. We agree that women and pregnant people need to be communicated with in an appropriate way and given information in an appropriate format and this detail is already included in the separate sections of the caesarean birth guideline called 'provision of information' and 'shared decision making'. Further detail on communication and treating people as individuals is covered in the NICE guideline on Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, and so this information is not repeated in all other NICE

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			People may not be able to articulate their concerns, feelings and specific reasons for their request. We strongly suggest clinical staff pay attention to healthcare passports: Some people with a learning disability and some autistic people may have a healthcare passport giving information about the person and their health needs, preferred method of communication and other preferences. Ask the person or their accompanying carer if they have one of these. We strongly suggest where there is reference to information and decision making, that all information is available in accessible format. This may include but is not limited to easy read and plain English versions of written information.	guidelines. However, we are aware that healthcare passports are becoming more widely used and are not referred to in the Patient experience guideline and so this comment will be passed to the NICE surveillance team which monitor key events relevant to the guideline.
NHS England	Table	General	We strongly suggest reference to making reasonable adjustments: This is a legal requirement as stated in the Equality Act 2010 and is important to help you make the right diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. However, the recommendations already advise that the health professionals providing perinatal mental health support are able to access the place of birth with the woman or pregnant person to provide support to help overcome fears

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			person to receive the assessment and treatment they need. This is an importance consideration in care planning and birth choice considerations. In this instance, examples of reasonable adjustments may include viewing theatre in advance of surgery if caesarean birth agreed, having list of people who might likely be in theatre (e.g. the number of people and their roles/how they support etc.), We strongly suggest consideration for existing multidisciplinary input into the care of the person. Consideration should also be given to the role of an organisation's learning disability team or liaison nurse on issues of communication, reasonable adjustments, pain assessment etc. Where an Acute Liaison Nurse is not available, we strongly suggest liaising with the local Community learning disability team.	and concerns, and this may include viewing theatre as you have suggested. The recommendations already state that discussions about maternal request caesarean birth should be undertaken by midwives, obstetricians, anaesthetists and healthcare professionals with expertise in perinatal mental health support, as appropriate so multidisciplinary care is already recommended. Any communication with a person with learning disabilities in any aspect of the NHS would be expected to follow the guidance in the NICE guideline on Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, and so this information is not repeated in all other NICE guidelines.
NHS England	Table	001	Where there is reference to pain relief, we strongly suggest making reference to clinical staff being aware of diagnostic overshadowing: This occurs when the symptoms of physical ill health are mistakenly either attributed to a mental health or behavioural problem or considered inherent to the person's learning	Thank you for your comment. The recommendation about pain relief in this context is about making sure women and pregnant people are aware of the pain relief options that are available to them, and therefore planning adequate pain relief as you suggest. The later sections of the caesarean birth guideline provide detailed advice on the use of pain relief during

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			disability or autism diagnosis. We strongly suggest adequate pain relief is planned for.	caesarean birth and the intrapartum care guideline provides detailed advice on the use of pain relief during vaginal birth, and were not part of this update. However, we agree that diagnostic overshadowing may be an issue for women and pregnant people from certain under-represented groups (such as those with learning difficulties, mental health comorbidities or from some ethnic groups) and so this issue has been added to the Equality Impact Assessment. This comment will also be passed to the NICE surveillance team which monitor key events relevant to the guideline.
NHS England	Table	001	**1.2.25** The amended recommendation is quite prescriptive in both language and approach and does not reflect the differing structures/processes for birth options provision amongst providers, nor the role of women's choice in whom they might wish to discuss their concerns with e.g.s 'ideally in a birth options clinic' - Unclear of the evidence for specifically named 'birth options' clinics being in place within a service. The key is that this is a longer appointment (within an	Thank you for your comment. The committee were aware of the healthcare professionals who would most commonly be involved in discussions about the choice of mode of birth (midwives, obstetricians, anaesthetists and professionals with expertise in perinatal mental health support) and so named these in their recommendations. However, if women or pregnant people wish to discuss their decision with others then that would be their choice to be discussed locally, but it would not be appropriate to list these in the guideline. As you have suggested the wording of the recommendation has been amended to clarify that discussions should be 'offered'.

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			antenatal setting – could even be home if the woman is vulnerable) with dedicated time to discuss birth options in detail. Note that referral out to birth options clinics can sometimes disrupt continuity of carer (midwifery/obstetric) where this is in place. It suggests a cons midwife should by default be the first port of call, with the obstetrician 'if necessary'. However, birth options discussions are facilitated by different personnel within different clinics/settings both between and within providers. In addition, it is not unreasonable for a woman to want to speak to a practitioner who does the operation they have requested as a first port of call, and it is not unknown for women to report in birth reflections or complaints processes that they felt barred from accessing an obstetrician regarding ELCS antenatally. Less prescriptive language e.g. offer discussion with a senior or consultant midwife or obstetrician… could mitigate this. Building on the comment above consider less prescriptive language e.g. offer discussion with a consultant midwife or senior obstetrician in a birth options clinic or equivalent.	The committee advised that with the increase in the number of consultant midwives the availability of birth options clinics or birth options appointments (which are, as you state, longer appointments which could be held anywhere) are becoming more common. The committee agreed that an obstetrician should always be available to be involved in such discussions if necessary but have amended this recommendation to clarify that this should also be if requested by the woman or pregnant person. The decision to suggest that the majority of detailed discussions could at least be initiated by a senior or consultant midwife was based on a concern for the resource implications of mandating that every women must be seen by an obstetrician. The recommendations suggest that a birth options clinic or appointment is the ideal but do not advise that this is the only way these discussions can be held, if units wish to deliver their services in other ways.

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NHS England	Table	002	**1.2.26** It would be helpful to clarify that the overall benefits and risks of caesarean birth should be compared with '**the overall benefits and risks'** of vaginal birth Provision of the material facts is a critical part of the consent process. NICE should list the core material facts relating to elective caesarean section and planned vaginal birth which should be given when providing the overall benefits and risks of caesarean birth should be compared with '**the overall benefits and risks'** of vaginal birth.	Thank you for your comment. The committee agreed that it was not necessary to complicate this sentence by repeating the phrase 'overall benefits and risks'. The guideline already contains a separate section on the benefits and risks of caesarean birth which was not part of this update, but which is cross-referenced so these facts have not been relisted.
NHS England	Table	004	We strongly suggest where there is reference to "severe anxiety about childbirth (for example, following abuse or a previous traumatic event)", we strongly advise the application of a trauma informed response. We strongly suggest these factors should be made as part od wider considerations regarding medical considerations for a caesarean birth.	Thank you for your comment. The scope of this update was to consider maternal request caesarean birth, and not make wider recommendations on the role of trauma as a medical consideration for maternal birth, but we will pass your comment to the NICE surveillance team which monitor key events relevant to the guideline to consider the need for more detailed recommendations on this topic.
NHS England	Table	005	**1.2.29** 'Ensure healthcare professionals providing perinatal mental health support are able to access the planned place of birth with the	Thank you for your comment. This recommendation only applies to women or pregnant people who are receiving perinatal mental health support for tokophobia or other

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			woman or pregnant person during the antenatal period': Knowledge of the environment +/- adjuncts to assist with description may be helpful for the health professional. However this recommendation is unlikely to be feasible in many units because of service burden/capacity in the birthplace, workload of the mental health professional, numbers of women requesting CS without medical indication etc. This also creates potential inequality in access to this between those requesting CS without medical indication vs those discussing birth options in other contexts.	severe anxiety about childbirth and has been in the guideline since 2011 so this is not a change to current practice. As this is individualised care to ensure that these women and pregnant people receive the care and support they need for their particular concerns then the committee did not agreed that this created an inequality.
NHS England	Table	007	In the "impact of change" column, we strongly suggest the wording is amended to say 'women with disabilities who find it difficult to travel or feel anxious about change' rather than just 'women with disabilities who find it difficult to travel' as the current wording does not appropriately recognise the impact/existence of non-physical disabilities.	Thank you for your comment. This change has been made.
NHS England	Table	007	**1.2.31** Given that an emergency CS (with greater risk than a planned CS) can never be ruled out if a woman pursued a vaginal birth, an absolute clinical reason not to perform a planned Caesarean section would be extraordinarily	Thank you for your comment. The committee has amended the wording of this recommendation to state that a maternal request caesarean birth should be offered in the woman or pregnant person's obstetric unit. The information about the extremely rare cases where a caesarean birth

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			unlikely. The wording in this recommendation and the idea that a hcp would be unwilling to perform a planned CS after informed decision making, sits extremely uncomfortably. Clarification that an MDT approach should be taken in the case of significant clinical risk factors could be inserted here without the current and proposed wording which seems to make allowances for conscientious objection.	may not be advisable has been left in the rationale and not moved into the recommendation as the committee agreed that this was such a rare occurrence that it would weaken the recommendation to suggest clinical reasons could be used to 'deny' maternal request caesarean births.
NHS England	Table	001 & 007	We strongly suggest these rows are expanded to include a bullet that references the Mental Capacity Act and how this should be followed and how Best Interest processes should be used for women and pregnant people that lack capacity.	Thank you for your comment. Adhering to the requirements of the Mental Capacity Act (and acting in the best interests of people who lack capacity) is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline.
Pregnancy Associated Osteoporosis (PAO) Patient Group UK	General		1.1.1 With regard to rare pregnancy associated osteoporosis (PAO) where spines & hips can break in labour, we feel that women at risk or having been diagnosed of this particular rare and devastating pregnancy related condition, should be allowed to have a caesarean birth, if wished, given this method of birth places the least strain on the skeleton and the least risk of further / new fractures to the vertebrae &/or hips or other bones. Given this is an ultra-rare disease, about which little is known, but which is	Thank you for your comment. The committee agreed that women or pregnant people with this rare condition would be cared for by a multidisciplinary team including orthopaedic specialists and an individualized decision about the most appropriate mode of birth would be agreed with the woman or pregnant person. The guideline already includes information in the section on 'benefits and risks of caesarean and vaginal birth' which states 'there are other risks not included in these tables that might be relevant to their individual circumstances' and

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			currently undergoing new ground-breaking UK research, then it is important for health professionals to understand this disease is little known or fully understood and evidence can appear to be low or non-existent in regard to rare diseases and therefore NICE should note and make account of the fact that evidence should not strictly be required and women's concerns and preferences with regard to this rare pregnancy related disease and birth should be respected and their preferences followed.	consideration of pregnancy associated osteoporosis and other rare conditions would fall under this recommendation so no changes have been made to the recommendations on maternal request caesarean birth.
Royal College of Anaesthetists	Table	1	It states *"discuss alternative birth options for example place of birth, continuity of midwifery care, pain relief options".* -This is potentially misleading: continuity of midwifery care may not be available. -This ignores the most common reason women ask for CS: concerns around safety of baby. To respond to her request with a discussion of home birth for example could seem as insensitive/not patient centred	Thank you for your comment. Midwifery Continuity of Care has been rolled out across England and should be the default model of care since March 2023, but we recognise that there are some areas where safe staffing levels may not allow for this to be fully implemented so have added 'where available' as you suggest. The committee agreed that women and pregnant people may request a caesarean because of concerns around safety, but also that some women and pregnant people's concerns about the birth process may relate to women's fear of having a long labour in an unfamiliar and clinical hospital environment, or concerns about pain and that ensuring women and pregnant people knew about the options for birthing centres or home

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				birth, or about the pain relief options may, in some cases, alleviate these concerns.
Royal College of Anaesthetists	Table	2	It states *"discuss benefits and risks of caesarean birth compared with vaginal birth"* -This is an **invalid** comparison. It suggests wrongly that that if you choose a vaginal birth you will get one. The risks of emergency CS and assisted vaginal delivery must be discussed in this context.	Thank you for your comment. Although data on planned caesarean birth and planned vaginal birth would be ideal to address the issue you have raised it is not widely available. The section of the caesarean birth guideline on planning mode of birth referred to from this recommendation therefore does not always use data from planned caesarean birth and planned vaginal birth (this is explained fully in appendix A), and this section of the guideline also provides more information on the need for emergency caesarean births in women and pregnant people who may plan for a vaginal birth.
Royal College of Obstetricians and Gynaecologists	Table	General	It is clear and easily understood.	Thank you for your comment.
Royal College of Obstetricians and Gynaecologists	Table	General	This looks fine to me. Nothing further to add.	Thank you for your comment
Royal College of Obstetricians and Gynaecologists	Table	General	The changes make sense and do provide the necessary clarification that was needed in addressing the issues. I have nothing further to add.	Thank you for your comment

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Stakeholder	Document	Line No	Comments	Developer's response
Royal College of Obstetricians and Gynaecologists	Table	General	I think the changes are appropriate and well structured.	Thank you for your comment
Royal College of Obstetricians and Gynaecologists	Table	General	I would agree with my colleagues that they seem fairly straightforward and pragmatic.	Thank you for your comment
Royal College of Obstetricians and Gynaecologists	Table	1.2.25	"When a woman or pregnant person with no medical indication for a caesarean birth requests a caesarean birth: • discuss and explore the reasons for the request • ensure they have accurate information • discuss alternative birth options (for example, place of birth, continuity of.." Could we just omit "..a woman.." and just state "When a pregnant person with no medical….."	Thank you for your comment. The additive wording using both 'woman and pregnant person' is in accordance with NICE's style guide. The NICE style guide sets out how we approach language and achieve consistency in our communications. We make it available on our website in the interest of openness and transparency. Our style guide is regularly reviewed and updated following feedback from internal users, interested stakeholders, committee members and the wider public. The most recent update was published in February 2023. Our priority is to ensure our guidance is safe, clear and inclusive for all our audiences.
Royal College of Obstetricians and Gynaecologists	Table	1 – 1.2.25	Bullet point 1 - 'ensure they have accurate information' Suggest provide written information / signpost to RCOG patient information leaflet 'considering a caesarean birth'	Thank you for your comment. We agree that women and pregnant people need to be given information in an appropriate format and this detail is already included in the separate section of the caesarean birth guideline called 'provision of information' so it has not been repeated here. It is not usual in NICE guidelines to refer to leaflets produced by other organisations.

Caesarean birth maternal request

Consultation on draft guideline - Stakeholder comments table
02/05/23 – 15/05/23

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Line No	Comments	Developer's response
Royal College of Obstetricians and Gynaecologists	Table	1 – 1.2.25	Bullet point *'record that this discussion and decisions*' Suggest it includes a readable format / pro forma to enable the mother to review the record of the conversation.	Thank you for your comment. Further details on sharing copies of healthcare information are covered in the NICE guideline on Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, and so this information is not repeated in all other NICE guidelines.

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*