Antenatal care update

Consultation on draft scope
Stakeholder comments table plus developer's responses

ID	Type	Organisation name	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
1	SH	Action on Smoking and Health	General	General	ASH welcomes the reference to NICE Guidance PH48 and PH26 in relation to supporting women to quit smoking during pregnancy. However, given that smoking is the leading modifiable risk factor for poor birth outcomes, and that national SATOD data shows there has been no decline in rates of smoking at time of delivery for the last 4 quarters ASH believes that further prominence should be given to smoking cessation within the Scope.	Thank you for your comment. We agree with you about the importance of smoking cessation in the context of antenatal care and although we will not be conducting an evidence review, the guideline will signpost to existing relevant NICE guidelines PH48 and PH26. This means that a section on smoking cessation will be included in the short guideline linking to the relevant recommendations included those guidelines.

2	S H	Action on Smoking and Health	11 – 12	28 – 32 & 1-4	The main outcomes for the Scope include reducing both maternal and infant mortality and major morbidities as well as increasing birth weight, given this we feel that more prominence should be given to smoking cessation during pregnancy. Smoking is the leading modifiable risk factor for poor birth outcomes, with an estimated 5,000 miscarriages and 2,200 premature births attributed to maternal smoking during pregnancy each year (Passive smoking and children, RCP 2010). Further given the stated outcome in the scope is to reduce infant mortality up to 1 year of age, it should be noted that if children were not exposed to tobacco smoke the number of sudden infant deaths could be reduced by over 30% (BMA 2004, & Abbott LC, Winzer-Serhan UH 2012). These outcomes will not be achieved without healthcare professionals supporting a continued decline in rates of smoking during pregnancy.	Thank you for your comment. We agree with you about the importance of smoking cessation in the context of antenatal care and although we will not be conducting an evidence review, the guideline will signpost to existing relevant NICE guidelines PH48 and PH26. This means that a section on smoking cessation will be included in the short guideline linking to the relevant recommendations included those guidelines.
3	S H	Action on Smoking and Health	10	18 – 22	Smoking and smoking cessation are included in the Scope under 'Lifestyle'. Given that smoking is an addiction of childhood with the majority of smokers starting before the age of 18 and that nicotine as delivered through tobacco smoking is highly addictive, we feel it is inappropriate to include smoking as a 'lifestyle' choice. Rather we would recommend smoking cessation is included under the section: 'Content and delivery of antenatal care' as delivery of smoking cessation advice and support should form part of routine care for all women who smoke. ASH has recently undertaken a literature review on reducing pregnant women's exposure to secondhand smoke, and feel that NICE Guidance could benefit from taking account of this growing body of evidence which also has a bearing on postnatal care. Since the publication of NICE PH26 further evidence has been published on the efficacy of incentive schemes for encouraging smoking cessation in pregnancy with new studies currently in progress. As the use of incentives is widely debated, the NICE Guidance might benefit from a review of this literature. In July 2017 ASH on behalf of the Smoking in Pregnancy Challenge Group published the report Smokefree Skills: An assessment of maternity workforce	Thank you for your comment. We agree with you about the importance of smoking cessation in the context of antenatal care and although we will not be conducting an evidence review, the guideline will signpost to existing relevant NICE guidelines PH48 and PH26. This means that a section on smoking cessation will be included in the short guideline linking to the relevant recommendations included those guidelines. We agree that smoking cessation advice and support should form part of

					training. This report found that there is a serious gap in knowledge and understanding of the impacts of smoking in pregnancy, confidence to raise smoking with pregnant women and the skills needed to support a change in behaviour, recommendations from NICE could be effective in addressing this skills gap.	routine care for all pregnant women who smoke and we will signpost the relevant NICE guidelines as well when drafting the recommendations related to those areas.
4	S H	Action on Smoking and Health	7	26	The NICE Guidance on Postnatal Care up to 8 weeks after birth is in development and should be included under that heading.	Thank you for your comment. This guideline is included both as the current 'published' version (p.7 line 26) and also 'in development' (p.8 line 10).
5	S H	Action on Smoking and Health	7	27 – 28	The newly published NICE Guidance on Smoking cessation interventions and services NG92, should be included and may now supersede the recommendations included in PH1.	Thank you for your comment. The newly published NICE guideline on smoking cessation interventions and services (NG92) has been added to the related NICE guidance list https://www.nice.org.uk/guidance/ng92 NG92 has replaced PH1 so this has been removed from the related NICE guidance list. PH26 and PH48 are still

						current guidelines, although there are plans in development to merge the tobacco guidance into a single tobacco guideline which is due to publish in January 2020.
6	SH	Action on Smoking and Health	9	7to8	While it is important that healthcare during pregnancy puts women and their partners/families at the centre of their care, these questions focusing on what women and their families 'value' might be slightly taking away from the information that they need, in order to have a healthy pregnancy. One reason reported by Midwives for not discussing smoking behaviours with pregnant women is that doing so might put strain on their relationship and that women don't want to talk about it. Therefore smoking cessation advice may not always be something that women/their families 'value' but it is necessary in order to reduce chances of complications during pregnancy and for the health of the infant. ASH would recommend reframing these questions so they focus more on what information women and their families need to ensure a healthy pregnancy.	Thank you for your comment. Whilst we understand your point about the balance of "need" and "value" both will be covered by the evidence review.
7	SH	Action on Smoking and Health	4	17	ASH considers the equality impact assessment insufficient. While disability is an important consideration in the delivery of antenatal care, socioeconomic status and age should also be considered. Younger mothers and mothers in lower socioeconomic groups are more likely to smoke while pregnant and throughout pregnancy, this increases the risk of still births, neonatal deaths, low birth weight and preterm birth (Infant Feeding Survey 2010, Dietary supplements, smoking and drinking). ASH would strongly recommend that the equality impact assessment is reviewed to include greater consideration of age and economic status.	Thank you for your comment. We agree that age and economic status are significant factors to consider during antenatal care. The reason why they are not covered in the equality impact assessment is because they are explored in the pregnancy and complex social factors NICE guideline. for further details please see CG110 https://www.nice.org.uk/Guidance/CG110

8	SH	Alliance Pharmaceuticals Ltd	1	24	"Although pregnancy is straightforward for most women…". This statement is inaccurate; around 80% of all pregnant women suffer with nausea & vomiting of pregnancy [ref: RCOG guidelines 2016; p5 of Royal College of Obstetricians and Gynaecologists Guidelines] and is critical that the aforementioned statement is factual.	Thank you for your comment, nausea and vomiting are common symptoms of pregnancy and will be covered in the guideline. They do not in themselves make the pregnancy other than straightforward.
9	SH	Alliance Pharmaceuticals Ltd	11	5 7 9 11 13 15	"Interventions for common problems during pregnancy" section. As discussed at the workshop in London, important to not just look at "effectiveness" of the 6 interventions being looked at, please kindly consider inserting the additional descriptor of, "effective and safe" or some such wording to reflect to any reader that these interventions are being looked in terms of effectiveness as well as safety (benefit vs, risk). There is much social anxiety with both patients and healthcare professionals to any intervention during pregnancy, so the safety data must be rigorously introduced and described.	Thank you for this comment. Please note that we have amended the scope in relation to the comment. We agree that considering both benefits and risks/harms of interventions is important and will interpret 'effectiveness' as including reducing the risk of poor outcomes and avoiding harms. We will look for outcomes including fetal death, preterm birth, and treatment-related adverse events. However, since we will not be reviewing the evidence on the teratogenic effects of pharmacological interventions (but rather referring to the Medicines and Healthcare products Regulatory Agency (MHRA) and the British National Formulary (BNF) for information about safety of

						specific drugs where relevant), we will be removing mention of safety from the relevant questions as they appear in the scope to avoid the expectation that our reviews would be addressing these issues.
10	SH	Alliance Pharmaceuticals Ltd	11	5 & 6	In reference to your question 1 above: "Which interventions or forms of practice might result in cost saving recommendations if included in the guideline?", would like to signpost NICE to the recent RCOG 2016 Guidelines on the best management of nausea and vomiting of pregnancy (NVP) which are the first ever by RCOG and are extremely comprehensive, but still relatively unknown to GP's or midwives. These are peer-reviewed, evidence based, specialist driven and independently created. We have data-on-file from a study conducted in 2016 (being submitted for publication) where there is huge variability in GP prescribing between practices and 1/3 of women re-present to their GPs due to uncontrolled symptoms; many more either call 111 or get an ambulance dispatch via 999 or present to A & E. The RCOG guidelines have been designed to offer guidance to healthcare professionals on both conservative and therapeutic measures to best control NVP which could reduce costs to the NHS and enable/ empower women to self-manage their condition more at home. Of particular note: (PAGE 2) "How should the woman be managed? Women with mild NVP should be managed in the community with antiemetics." (PAGE 3) "What is the safety and efficacy of pharmacological agents? There are safety and efficacy data for first-line antiemetics such as antihistamines (H1 receptor antagonists) and phenothiazines and they should be prescribed when required for NVP and HG." (PAGE 6) "How can the severity of NVP be classified? An objective and validated index of nausea and vomiting such as the Pregnancy-Unique Quantification of Emesis (PUQE) score can be used to classify the severity of NVP" The NHS UKMi report on NVP management (updated March 2017) also offer a	Thank you for your comment. We can only refer to national policy or NICE guidance and therefore cannot refer to RCOG green top guidance. The committee will look at interventions for effective treatment of nausea and vomiting in pregnancy in question 10.1, though we cannot pre-empt recommendations made by the committee on clinical or cost effectiveness.

					comprehensive review of the literature and offesr additional guidance for inclusion which would hopefully mean a more consistent approach to the management of women with NVP and allow better control of symptoms to reduce the ongoing need to access NHS services.	
11	SH	Association of Breastfeeding Mothers	1	23	More specific recognition of fathers/ co-parents is needed in the language in this document. 'Better Births' reports highlighted fathers felt excluded, their role was not recognised and as a result opportunities were missed to support the family. I don't feel 'and families' should be used a term that might de-emphasise the involvement of fathers/ co-parents. They should be specifically highlighted (with reference to the fact some women may not have a partner).	Thank you for your comment. With regards to equality, the guideline refers to partners without assigning a gender as this is non-discriminatory and protects women's choice
12	SH	Association of Breastfeeding Mothers	4	8	"women, their partners/ co-parents, their families and the public"	Thank you for the comment. We have revised this section as you suggest.
13	SH	Association of Breastfeeding Mothers	5	9	As above	Thank you for the comment. We have revised this section as you suggest.
14	SH	Association of Breastfeeding Mothers	9	12	Valued by women and their partners/ co-parents	Thank you for your comment. The point you make will be considered by the committee during protocol development of the evidence review question on peer support that is valued by women.

15	SH	Association of Breastfeeding Mothers	9	21	As above	Thank you for the comment. We have revised this section as you suggest.
16	SH	Association of Breastfeeding Mothers		general	National Maternity Review states: “Some women told us that they relied on their partner to support them in pregnancy and with the care of the baby and the NHS needed to recognise this and help their partners to help them.” An additional question in response to this issue from Better Births could be, “What is the most effective way of enabling partners to support women?”	Thank you for your comment. We have added a review question on "What approaches are effective in involving partners during antenatal care?"
17	SH	Birth Trauma Association	Page 3	General	We urge the GDG to include guidance on caring for pregnant women before a risk factor for GBS infection is identified, including what information is provided, when and by whom. We are concerned it may have been assumed that this has been included in the Neonatal Infection Guideline but this is not the case. The RCOG published an updated Greentop on Group B Strep and RCOG recommended that all women should be provided with an information leaflet on Strep b. It is important that Greentops and NICE guidance align to enable staff and families to be clear about what care should be offered. 20-30% of normal healthy women carry the bacteria and early-onset GBS (EOGBS) infection is a leading cause of severe infection in babies, and a significant cause of neonatal mortality and morbidity. It can result in enormous costs to the NHS and enormous distress to families. Worryingly, it is also an increasing problem; cases have risen by 37% between 2000/1 and 2014/5 (Group B Streptococcal disease in infants. Heath P. BPSU Annual Report 2015-2016. (2016). London: British Paediatric Surveillance Unit, pp.10-	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
18	SH	Bliss	6	26	We welcome the inclusion of the ‘Preterm labour and birth’ in the list of related guidelines, however the link needs updating to the correct guideline. It currently links through to the ‘Hypertension in pregnancy’ guideline.	Thank you for your comment. The hyperlink is now correct: https://www.nice.org.uk/guidance/ng25

19	SH	Bliss	9	6to14	Add question: “What information can help prevent poor outcomes”. Rationale:In September 2017, the Royal College of Obstetricians & Gynaecologists published a major update to their Greentop guideline on group B Strep, recommending that all pregnant women should be provided with an information leaflet about group B Strep (Hughes RG, Brocklehurst P, Steer PJ, Heath P, Stenson BM on behalf of the Royal College of Obstetricians and Gynaecologists.	Thank you for your comment and for the suggested reference. We anticipate that data about the most effective information including information regarding GBS (to promote positive outcomes and reduce poor outcomes) will be addressed through the evidence reviews about information and support for women and their families.
20	SH	Bliss	General	General	Bliss believes that measures to prevent group B Strep (GBS) infection in newborn babies should be covered explicitly in this guideline. 20-30% of normal healthy women carry the bacteria and early-onset GBS infection is a leading cause of severe infection in babies, and a significant cause of neonatal mortality and morbidity. It is also an increasing problem - according to the latest BPSU study, the rate of early-onset GBS infection increased in the UK & Republic of Ireland by 19% (and the number of cases by 37%) between 2000/1 and 2014/5 (Group B Streptococcal disease in infants. Heath P. BPSU Annual Report 2015-2016. (2016). London: British Paediatric Surveillance Unit, pp.10-12. http://www.rcpch.ac.uk/system/files/protected/page/BPSU_AR1516_Web_0.pdf). The NICE Neonatal Infection (early onset) guideline (referenced in scope) covers preventing infection within 72 hours of birth in healthy babies, treating pregnant women whose baby is at risk, and caring for babies who have a suspected or confirmed infection.” However, guidance is needed on caring for pregnant women before a risk factor for early-onset GBS infection is identified, including what information is provided, when and by whom. We recommend that this guidance addresses this issue.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.

21	SH	Bliss	General	General	The scope should reference the updated Royal College of Obstetricians & Gynaecologists published Greentop guideline on group B Strep. (Hughes RG, Brocklehurst P, Steer PJ, Heath P, Stenson BM on behalf of the Royal College of Obstetricians and Gynaecologists. Prevention of early-onset neonatal group B streptococcal disease. Green-top Guideline No. 36. BJOG 2017;124:e280–e305. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg36/).	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
23	SH	Britegg	General	General	We would like to respond re section 1.3 Lifestyle considerations, under 1.3.3 Food acquired infections but only specifically 1.3.3.2 This currently reads as follows and clearly needs updating. 1.3.3.2 Pregnant women should be offered information on how to reduce the risk of salmonella infection by: • avoiding raw or partially cooked eggs or food that may contain them (such as mayonnaise) • avoiding raw or partially cooked meat, especially poultry. The Food Standards Agency has recently updated its advice on consumption of raw and partially cooked eggs for vulnerable groups. The new advice is that it is now safe for pregnant women, babies and elderly people to eat raw and partially cooked eggs, as long as they have the British Lion mark on. The advice is on the FSA website here https://www.food.gov.uk/news-updates/news/2017/16597/new-advice-on-eating-runny-eggs	Thank you for your comment. The 2008 NICE antenatal guidance will be stood down once this guideline is published. We agree with you about the importance of preventing salmonella infection in the context of antenatal care and this guideline will signpost to the relevant NHS guidance.

24	SH	British Acupuncture Council	6	3	Complementary therapies (CT) were included as possible treatment options in the 2008 guideline, specifically ginger and acupressure for early nausea and vomiting. For the new version it is proposed to exclude CT entirely, despite the widespread public interest in using such treatments during pregnancy (a time when pharmaceutical options are limited) and indeed widespread use by some midwives. This exclusion seems to follow a general trend to reduce CT representation, both at a scoping level (palliative and supportive care was a notable example; the decision was subsequently reversed after concerted objection at the comment stage), and in final guidelines (e.g. osteoarthritis, low back pain). One can only speculate as to the reasons for this: as with palliative/supportive care no explanation has been given as to why CT are to be excluded. According to the surveillance review no new evidence was sought, so it doesn't appear to have a scientific basis. We can see that there is more evidence available for acupuncture/acupressure than in 2008 (we are not in a position to comment on other CT). Nausea and vomiting has been the main area for these studies, as shown by its inclusion in CG62, but systematic reviews are now apparent for other symptoms. Liddle and Pennick's 2015 Cochrane review on back and pelvic pain is a case in point. The indications are that acupuncture is as effective as any other intervention for pelvic pain, or combined low back and pelvic pain. Pelvic pain is one of the pregnancy symptoms covered by the scope, so we would expect to see acupuncture evaluated alongside other interventions. There is also increasing evidence supporting acupuncture for mental health problems in pregnancy (van Ravesteyn et al, 2017). We appreciate that the latter are excluded from the scope, being the subject of a separate guideline. This may make sense for conventional interventions but for acupuncture, as with many CT, a combined body-mind, holistic approach is intrinsic to theory and practice. Perhaps in future NICE could consider the advantages of interventions that do more than pick off one symptom at a time, but can act as a central resource for patients over extended periods (Pagones et al, 2017). There has also been increasing evidence of the safety of acupuncture in pregnancy (Liddle and Pennick, 2015). We note that NICE guidelines do not impact just on NHS provision directly. They also influence the advice and recommendations that GPs and other orthodox health professionals make in relation to private practice, which may indirectly reduce the NHS burden. Is this wider focus taken into account?	Thank you for your comment. Evidence reviews for pelvic girdle pain and nausea and vomiting will include interventions of interest prioritised by the committee at protocol development, which may include complementary therapies. We have revised the section on 'Relation to previous NICE guidance on this topic' to address this.

25	SH	British Acupuncture Council	6	11	Why is backache to be excluded in this update? It reduces quality of life, increases take-up of sick leave, increases inductions and elective Caesareans etc. It is also one of the commonest reasons for pregnant women seeking acupuncture treatment.	Thank you for your comment. We acknowledge that the list of 'common problems' is not exhaustive and was drawn up through a process of prioritisation by the scoping group. focusing on those of potential major importance or those in which there is significant evidence. In the case of backache specifically, it was also noted that there is a comprehensive advice contained in NG59. For further details see: https://www.nice.org.uk/guidance/NG59.
26	SH	British Acupuncture Council	9	7	Is there not a need for health professionals to be able to give good information on CT, given that many women seek them out in pregnancy?	Thank you for your comment. This will be covered if the committee agrees that complementary therapies are an intervention of interest to be looked at during protocol development.
27	SH	British Acupuncture Council	9	28	Is not acupuncture (moxibustion) a possibly effective intervention for malpresentation (certainly some systematic reviews have found it to be so), and hence should be considered in the information given out on this? Many pregnant women know about it; many midwives know about it: NICE should be providing evidence based advice. Acu-moxibustion is being used in NHS maternity units currently, with obvious implications for cost saving by reducing the need for Caesarean section, never mind the effects on quality of life and future pregnancies	Thank you for your comment. This will be covered if the committee agrees that complementary therapies are an intervention of interest to be looked at during protocol development.

28	SH	British Acupuncture Council	11	5	Why is acupuncture/acupressure not to be considered here? As in the previous comment, there is considerable existing public awareness of this therapy for nausea and vomiting and this should be addressed in the guideline.	Thank you for your comment. This will be covered if the committee agrees that complementary therapies are an intervention of interest to be looked at during protocol development.
29	SH	British Acupuncture Council	11	11	As already discussed under 6/3 there is reasonably credible evidence to support acupuncture for pelvic pain. Why is it not to be reviewed for the guideline so that evidence based advice can be provided? Given the paucity of interventions that are both safe and effective it seems contrary to have removed acupuncture, as part of CT, from the scope. Is it not preferable to be able to offer patients more options? It could be delivered in groups, by midwives or others, for little cost.	Thank you for your comment. This will be covered if the committee agrees that complementary therapies are an intervention of interest to be looked at during protocol development.
30	SH	British Acupuncture Council	11	20-21	The case for using one intervention to treat both physical and co-existing mental health conditions has already been made above. Low-level anxiety and/or depression are fairly common in uncomplicated pregnancy and could be addressed in an integrated manner with acupuncture as part of a multi-disciplinary approach	Thank you for your comment. The management of anxiety in pregnancy is covered in CG192.
31	SH	British Pregnancy Advisory Service	9	16	We recommend an additional point 2.2 on what input pregnant women should have into the antenatal care provided to them. This is particularly relevant with regards to what extent women have a say in the type and location of their birth – including, but not limited to, vaginal delivery, pain relief, caesarean section, and midwife-led vs obstetric units. This is essential to ensure that care is patient-led.	Thank you for your comment. The points you make about type and location of birth will dealt with by signposting to the relevant NICE guidelines CG190 https://www.nice.org.uk/guidance/cg190 and CG132 https://www.nice.org.uk/guidance/CG132 and reflected in the protocols for the proposed questions on information and support of antenatal care.

32	SH	British Pregnancy Advisory Service	11	6	We recommend the inclusion of interventions for Hyperemesis Gravidarum (HG) as a sub-point to 10.1 (interventions effective in treating nausea and vomiting during pregnancy (NVP)). Up to 1% of pregnant women are admitted to hospital with HG, and severe pregnancy sickness can impact quality of life. As an organisation we see women who terminate wanted pregnancies because their sickness had become so severe – yet earlier intervention could have stopped symptoms escalating to the point that termination of pregnancy was requested.	Thank you for your comment. Hyperemesis Gravidarum (HG) will be covered in the evidence review of interventions for nausea and vomiting.
33	SH	British Pregnancy Advisory Service	11	17	Many women rely on prescribed medications for their own health and for whom stopping medication can be dangerous – most notably with regards to anticonvulsant and antidepressant medications. We understand that this review will not be concerned with the guidance around which medications to take during pregnancy for specific conditions, but believe there needs to be better communication of the benefits as well as the risks of medication for pre-existing conditions in pregnancy.	Thank you for your comment. This guideline will refer to relevant NICE guidelines on co-existing conditions such as epilepsy and obesity. The committee will consider the use of prescribed medication during the protocol development for the evidence review on what information women value. Please note that CG192 covers the use of anti-depressants.

34	SH	British Pregnancy Advisory Service	11	21	We recommend including guidance on the use of diagnostic tests and imaging both inside and outside antenatal care settings, particularly in relation to CT scans and x-rays where guidance can be conflicting and pregnant women can raise concerns about the safety of such tests.	Thank you for your comment. The committee will consider investigations in pregnancy during the protocol development for the evidence review on what information women value.
35	SH	British Pregnancy Advisory Service	11	22	We recommend a point 12 on foetal anomaly diagnoses. Existing guidelines include information on screening but not on the information provided to or the management of women and families who receive a diagnosis of foetal anomaly. We would expect the final guidance on this point to include screening, the provision of information and options to women and families receiving these diagnoses, referral for termination of pregnancy services where requested, and the availability of counselling. The final guideline should also include guidance on the management of women going through labour with a diagnosis of fatal foetal anomaly which currently generally takes place on labour wards, which can be exceptionally traumatic for women and families in this difficult position.	Thank you for your comment. We expect that screening and management of fetal anomaly will be covered by Fetal Anomaly Screening Programme (FASP) which will be signposted in the guideline recommendations. Please note that this information would be highly condition specific and is outside of the remit of this guideline. However, the guideline will be looking at information and support and we would expect it to arise in the qualitative evidence about the views and experiences

						of women and their families.

36	SH	Caesarean Birth (caesareanbirth.org)	General	Qu.1 above	1) 1) Which interventions or forms of practice might result in cost saving recommendations if included in the guideline? It's important not to assume that all 'low risk' (or women with "uncomplicated pregnancies") want midwifery-led care. Midwifery-led care is important and valuable for women who want a vaginal birth, but many women requesting a caesarean would prefer obstetrician-led care from the outset. This is an option in private maternity clinics, yet in the NHS, multiple appointments spanning numerous months and involving both midwives and obstetricians have been designed to handle maternal requests. For example: https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2016/march/3640-08-3-1-twccg-plcv-draft-document-v25a-march-2016/file Often when I refer to maternal request in NICE guidance, there is a response stating that this is covered in a separate guideline. However, maternal request caesareans (whenever the request arises) are a very present part of antenatal (and sometimes intrapartum) care, and it's increasingly important that they are considered alongside vaginal birth in the context of 'Information and support'. Keeping them entirely 'separate' maintains the status quo that the only decision women with "uncomplicated pregnancies" need to make is WHERE they give birth, and not HOW. This is not true. Midwifery care and resources are frequently cited by the RCM and others as being understaffed and overstretched, yet, as the above link demonstrates, some midwives spend significant amounts of their time dealing with maternal request caesareans, including one-to-one appointments, scheduling (often unwanted) mental health care appointments, obstetrician appointments, and sometimes managing clinics to discourage this choice. In this 2013 BMJ letter for example, professors and lecturers of midwifery explained their understanding of NICE CG132, and what their antenatal role is:	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

37	SH	Caesarean Birth (caesareanbirth.org)			"NICE suggests that when requests for caesareans are based on anxiety, mothers should be offered referral to a perinatal mental health professional. The recommendation is that a caesarean section should be offered only if this fails." https://www.bmj.com/content/347/bmj.f4649 Firstly, this is not true. NICE CG132 only recommends the "offer of support (including perinatal mental health support for women with anxiety about childbirth)"; NICE does not recommend all women must meet with a mental health professional before a caesarean is offered. NICE has estimated the cost of "Mental health support for women with anxiety about childbirth" as £1,053. Maternal requests themselves were not considered to have a substantial impact, but the "recommendation [for the provision of mental health support is] likely to lead to a resource impact for the NHS." Many women don't need or want mental health support when they request a caesarean, yet in some Trusts, it became a compulsory part of their antenatal care in order for the request to be considered: (2016) Mid-Essex CCG Threshold Approval for Caesarean Section file:///C:/Users/Pauline.Hull/Downloads/Caesarean%20Section.pdf "Elective Caesarean Section will only be considered when one of the following criteria is met: …Maternal request following an assessment by a health professional with expertise in perinatal mental health and meeting NICE guidance– see NICE. https://www.nice.org.uk/Guidance/CG132" Trusts refusing to pay for a caesarean on request unless a costly mental health assessment is carried out is not cost-effective.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
38	SH	Caesarean Birth (caesareanbirth.org)			Notably, women who request a homebirth are not automatically offered (or assumed to need) mental health counselling, and they do not have to wait until 36+ weeks' gestation before their birth plan request is confirmed. It's important to note here that my organisation is aware of cases where the woman's midwife has helped her to get support for her maternal request caesarean, by convincing a reluctant obstetrician. The question is whether antenatal care could work more efficiently, and be more effective, if caesarean birth was inclusive rather than exclusive? If mode of delivery was considered as an integral part of all women's antenatal care? 3) In 2017, the RCOG emphasised the lack of available resources for maternal mental health: "Key findings: -Women reported experiencing low rates of referral, long waits, regional variation of care, a lack of continuity of care, misunderstanding and stigma -The mental health of women's partners is also often neglected by healthcare professionals and services" (2017 RCOG Maternal Mental Health –	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

					Women's Voices) Again, this is not the most efficient use of resources. Only women who need or want access to mental health support should be offered it, but certainly women requesting caesareans who don't need or want it shouldn't be made to attend.	
39	SH	Caesarean Birth (caesareanbirth.org)	General	Qu.2 above	2) Are hospital maternity dashboards a helpful or harmful influence on antenatal care? My organisation's concern is the existence and physical presence of caesarean rate targets in NHS maternity care. Very often, the hospital's rates (elective, emergency, overall) are prominently displayed as they work. I'd like NICE to consider making a specific recommendation for there to be no "targets" for caesarean rates in hospitals, as this can have a direct impact on antenatal care, and outcomes. There is no known optimum rate, and it is clear from litigation cases that delayed or absent caesareans can result in deaths and injuries: https://caesareanbirth.org/2017/11/19/my-interview-with-dr-michael-magro-author-of-five-years-of-cerebral-palsy-claims/ It is so important for antenatal care, education and information to be balanced, and this cannot be achieved in environments where one of the assessed "outcomes" that determines whether staff and managers are criticised or praised is the hospital's caesarean rate.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
40	SH	Caesarean Birth (caesareanbirth.org)	General	Qu.3 above	Post Montgomery, and with women increasingly demanding full disclosure of both delivery mode risks, should caesarean birth (Planning mode of birth) be included in this antenatal update/pathway? Is it appropriate to focus solely on 'Planning place of birth'? The current antenatal care pathway for women who are planning a vaginal birth leads into "Pregnancy after 41 weeks" and "See what NICE says on intrapartum care". The latter doesn't include information on caesarean birth/choice, so where does a woman go on the pathway if she wants to request a caesarean at 39 or 40 weeks (for example)?	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

41	SH	Caesarean Birth (caesareanbirth.org)	General	General	My organisation genuinely hopes that NICE takes this opportunity to revise its antenatal care guidance to include caesarean birth/ planned mode of birth. A woman may plan a vaginal birth throughout her antenatal care, but then want to reconsider her options/choices if (for example) she is overdue. All too often, the options discussed at this point are to a) await spontaneous labour or b) be induced. Scheduling a planned caesarean is not offered/discussed as a standard of antenatal care (when it should be), and in some cases, the woman's request for a caesarean birth at this stage in her pregnancy can be refused. This is certainly clear in litigation cases, but also in social media/online discussions between women. I understand that there is 'separate' guidance for caesareans, but as communicated in other NICE consultations, this is not working effectively or efficiently. More women choose a caesarean birth plan than a homebirth plan, and it is really important for antenatal discussions to include caesarean birth risks and benefits (i.e. MODE of delivery, not just PLACE of delivery), even in "uncomplicated pregnancies." Women are demanding it, and guidance is needed for maternity professionals. If NICE is not convinced by me, may I suggest canvassing the views of litigation specialists, and ascertaining how many women with adverse outcomes began their pathway labelled "low risk" or "uncomplicated"? I understand that NICE does not include NHS Resolution (formerly NHSLA) data in its economic analysis, but I feel it's important to highlight the huge cost of obstetrics litigation here (including women with serious pelvic floor injuries, many of whom say they were 'never told about the risks').	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
42	SH	Caesarean Birth (caesareanbirth.org)	9	7	What information do women value as part of their antenatal care? Honest, balanced and complete information about mode and place of birth. They do not like facts being kept from them:https://caesareanbirth.org/2017/10/17/womens-voices-are-exposing-truth-about-pelvic-organ-prolapse/ Question: Would NICE consider recommending that maternal request caesarean data is specifically captured by NHS Digital (HES/MSDS) please? NICE CG132 (and numerous other publications) recognised a need for more research and better information about maternal request caesareans (how many women are requesting; what are the maternal and infant health outcomes). Women want this information, and so do medical professionals. It's important for supporting antenatal education, information and care. It's been 6.5 years since NICE recommended support for maternal request, and there is evidence from Trusts, clinicians and researchers that requests have increased, yet we are no closer to gathering important data from these births. This would be a	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

					simple and effective way to capture data, both in the short- and the long-term (e.g. investigating long-term effects on children).	

43	SH	Caesarean Birth (caesareanbirth.org)	9	8	1.2 What information do partners and families value as part of antenatal care? As above (comment #2).	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

44	SH	Caesarean Birth (caesareanbirth.org)	9	10	1.3 When should information be given during antenatal care?********This could be individualised (some women may not want to know 'everything' at once), but it should be offered at the first antenatal appointment (some women feel more comfortable understanding their options and making a plan immediately).	Thank you for your comment. The point you make will be considered by the committee during protocol development for the evidence review questions on information and support and we would expect it to arise in the qualitative evidence about the views and experiences of women and their families.
45	SH	Caesarean Birth (caesareanbirth.org)	9	11	1.4 How should information be delivered during antenatal care? Sensitively, and with respect for individual 'patient preferences'. Also, as objectively as possible (Montgomery 2015 identified issues with subjective communication): https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf "There is no question in this case of Dr McLellan's being entitled to withhold information about the risk because its disclosure would be harmful to her patient's health. Although her evidence indicates that it was her policy to withhold information about the risk of shoulder dystocia from her patients because they would otherwise request caesarean sections, the "therapeutic exception" is not intended to enable doctors to prevent their patients from taking an informed decision." There is evidently disagreement among health professionals as to whether advanced maternal age, short stature, maternal weight, suspected macrosmia, previous complications or obstetric family history (for example) are indicators for 'increased risk', and how/ whether these might affect communication or classification in an "uncomplicated pregnancy" discussion. Women should be made aware that this disagreement exists and provided with balanced information.	Thank you for your comment. The points you make about information provision during antenatal care will be considered with the committee during protocol development for the evidence review questions on information and support.

46	SH	Caesarean Birth (caesareanbirth.org)	9	14	1.6 How effective are antenatal classes and groups?********One of the complaints from women (in surveys and online discussions) is that antenatal classes can sometimes lean towards communicating vaginal birth benefits more than the risks. In particular, women who experience a traumatic birth sometimes say that the physical trauma was exacerbated by the shock of not being better prepared mentally for what might happen. In some NHS Trusts, as many as a third of women will give birth with forceps, ventouse or an emergency caesarean. This is the reality for some women, and a class that doesn't cover these may not be effective.	Thank you for your comment. The points you make will be considered with the committee during protocol development for the evidence review questions on the views and experiences of women and their families.
47	SH	Caesarean Birth (caesareanbirth.org)	9	17	2.2 What appointment timing is effective and safe in delivering antenatal care? This is a very important issue in the context of maternal request caesareans, whether the decision is made early or late in pregnancy. Here is what the 2016 South West London Maternity Network patient information leaflet on maternal request says: "Once a decision has been made for your elective procedure, you will be offered a date to come in to hospital. However, the timing of the operation will depend upon the clinical activity of the maternity unit and safety of all women in the unit at the time. Priority will always be given to women with clinical and/or obstetric need or for emergency situations." https://www.kingstonmaternity.org.uk/media/144466/Requesting-a-planned-caesarean-Kingston-Hospital-NHS-Foundation-Trust.pdf The above is contrary to NICE QS32 (June 11, 2013): "Planned caesarean section should be agreed between the woman and the maternity team. The woman should be given a specific day and time at which the caesarean section will be performed. A model for delivering planned caesarean section is for services to have dedicated planned caesarean section lists. The lists should have protected surgical and anaesthetic time and appropriate staffing to ensure that planned caesarean section are not delayed because of surgical time being prioritised for emergency cases." Also note this comment by The Royal College of Anaesthetists during the 2012/13 NICE Caesarean Section Quality Standard Consultation:	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

48	SH	Caesarean Birth (caesareanbirth.org)			"**The OAA feels strongly that women undergoing planned Caesarean section should have their delivery scheduled on a dedicated and time protected elective Caesarean section list. In the majority of hospitals (OAA survey data evidence), elective procedures are carried out in an ad-hoc manner and are frequently interrupted** by emergency Caesarean sections, other operative deliveries or obstetric procedures in theatre, or by obstetric, midwifery or anaesthetic staff becoming unavailable because of unforeseen demands on the labour ward. **The consequence is that elective sections are often postponed to the next working day or later**, despite the mother having been fully prepared and fasted, and often having placed other children into childcare arrangements for the day (audit data from Nottingham and other hospitals available to support this). **No other elective surgery in the NHS works to this haphazard model.**" This may be covered in CG132 on Caesarean section, but my organisation would like to see it included/reiterated in antenatal care guidance too. Women have communicated that during risk/benefit discussions during their antenatal care, they feel threatened by the fact that their planned caesarean could be delayed, and sometimes actually advised that if they go into labour prior to 39 weeks' EGA, they would be expected to attempt vaginal birth. Some women feel comfortable keeping this option open, but others definitely do not. Also, women should not be made to wait until late in their pregnancy/ antenatal care before their birth plan is agreed. It can create unnecessary and harmful anxiety and stress.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
49	SH	Caesarean Birth (caesareanbirth.org)	9	21	2.4 What aspects of antenatal care delivery are valued by women? The women my organisation represents value clarity, honesty, respect and genuine support. They would like to understand the clinical pathway for caesarean maternal requests (ideally via visiting the hospital website and finding information alongside other birth choices). They would like a timely discussion about risks and benefits, and an early decision regarding their request. This is to allow time to arrange the NICE CG132 recommended referral "*to an obstetrician who will carry out the CS*". It is also to avoid the unnecessary anxiety that can occur when discussions are drawn out over months, with various different clinical staff, not knowing what the outcome will be.	Thank you for your comment. The points you make will be considered by the committee when developing the protocols for the evidence review questions on information and support of antenatal care.

50	SH	Caesarean Birth (caesareanbirth.org)	9	22	2.5 Is continuity of carer effective in antenatal care, and is it valued by women? It may be effective, and is certainly valued by some women: Continuous support in labour may improve a number of outcomes for both mother and baby, and no adverse outcomes have been identified." (BohrenMA,HofmeyrGJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub6.) I've read concerns by some professionals that it may be challenging to deliver sometimes with shift work, holidays, sickness etc., but my organisation's main point here is to ask NICE to consider and include 'continuity of carer' in the context of both a midwife/midwifery team and an obstetrician/obstetric team. Many women with uncomplicated pregnancies who request a caesarean would like to meet with the same obstetrician (or a colleague who shares their view of maternal request) throughout their pregnancy. This is to avoid repeating their request, and to have assurance that if they go into labour early (and the obstetrician who agreed their request is not in clinic), their maternal request will still be supported.	Thank you for your comment and information. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. in the NICE guideline on patient experience in adult NHS services.
51	SH	Caesarean Birth (caesareanbirth.org)	10	5	4.2 What techniques (for example, fetal movement reporting and ultrasound) are effective in monitoring fetal wellbeing, and identifying problems, during pregnancy? An ultrasound scan to explore cord pathology should be offered as an option for all women who do not wish to rely on vaginal examination/ detection alone. Dr. Jason Collins (in the United States) has published some excellent work on this topic, particularly in the context of reducing stillbirth risk (an important aim of the current Department of Health). We understand more than ever before (ultrasound imaging is becoming increasingly clear) about the position of the umbilical cord and identifying knots; also amniotic fluid levels and the baby's position can often be assessed. This is an example of where an offered intervention (not all women will want it) can have very good outcomes for women and babies as it helps to assess likelihood of spontaneous and uncomplicated labour occurring, and can help to avoid foetal distress, prolonged labour, instrumental delivery and/or emergency CS, and the infant and maternal birth injuries associated with those.	Thank you for your comment. This guideline will look at evidence for routine third trimester scan to reduce stillbirths as part of the evidence review questions on monitoring fetal growth and wellbeing.
52	SH	Caesarean Birth (caesareanbirth.org)	10	16	6.1 How effective and safe is exercise in pregnancy for the mother and baby? The number of women who are overweight or obese when they become pregnant is unprecedented. The increased clinical risk for these women (whatever their birth plan), and even those with "uncomplicated pregnancies", is well documented. My organisation welcomes the inclusion of this important topic for review.	Thank you for your comment. Please note that physical activity in pregnancy will be included in the NICE guideline on

						weight management before, during and after pregnancy, when the guideline is updated and will not be covered by this guideline.
53	SH	Caesarean Birth (caesareanbirth.org)	11	30	(Main outcomes) - major morbidities (such as antepartum haemorrhage) My organization would like to request that pelvic floor damage is included here, if not already planned. Third and fourth degree tears are often captured, though there is evidence (e.g. in litigation cases) that these are often misdiagnosed or underdiagnosed prior to women leaving hospital. Is it possible for longer term follow-up of major morbidities including foecal incontinence, severe urinary incontinence and pelvic organ prolapse to be included?	Thank your comment. The information of pelvic floor damage lies within the scope of the intrapartum guideline CG190 . For further details please see https://www.nice.org.uk/guidance/cg190
54	SH	Caesarean Birth (caesareanbirth.org)	11	31	(Main outcomes) - women's experience and satisfaction of care This inclusion is very welcome. Could NICE please attempt to separate planned and emergency caesarean births in its search for this please? Most women with 'uncomplicated pregnancies' will have planned a vaginal birth, but there is research on birth satisfaction in women who planned a caesarean (without medical indication) that may not readily appear in a standard literature search for "antenatal care in uncomplicated pregnancies". For example: "Women planning cesarean reported a more favorable birth experience than women planning vaginal birth, due in part to low satisfaction associated with unplanned cesarean. Maternal satisfaction with childbirth may be improved by efforts to reduce unplanned cesarean, but also by support for maternal-choice cesarean." (Joan l Blomquist et al., "Mothers' Satisfaction with Planned Vaginal and Planned Cesarean Birth," American Journal of Perinatology 28, no. 5 (May 2011): 383–88.) "On a scale from 1 (totally unsatisfied) to 10 (completely satisfied), the mean satisfaction rating reported was 9.25/10 (95% confidence interval: 8.89, 9.60). (Stephen Robson et al., "Elective Caesarean Delivery at Maternal Request: A Preliminary Study of Motivations Influencing Women's Decision Making," Australian and New Zealand Journal of Obstetrics and Gynaecology 48, no. 4 (August 2008): 415–20.)	Thank you for your comment. We will be looking at women's experience and satisfaction of antenatal care only.

55	SH	Caesarean Birth (caesareanbirth.org)	12	1	(Main outcomes) - for the baby Would NICE consider including "stillbirth" (or "perinatal mortality") on its own here, in addition to infant mortality?	Thank you for your comment. We agree with your suggestion and the final scope has been amended accordingly.
56	SH	Caesarean Birth (caesareanbirth.org)	12	11	When this guideline is published, we will update the NICE Pathway on antenatal care.My organisation notes that the current Pathway on antenatal care does not refer to caesarean birth, although it does include a pathway for "*Non-routine and complicated pregnancies*". The problem with this is the assumption that after "*Information and support*" in the pathway diagram, the only decision or plan that women will make is "*Planning place of birth*". Assuming that "*maternal requests*" are designed to move down the "*Non-routine and complicated pregnancies*" towards CG132 recommendations (which we know not all Trusts follow), the updated Pathway still needs to include "*Planning mode of birth*", as there will be women who decide to plan a caesarean birth following "*Information and support*". Does NICE agree?	Thank you for your comment. The NICE pathways will need to reflect the areas covered by this guideline and by those covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and CG190 https://www.nice.org.uk/guidance/cg190.
57	SH	Caesarean Birth (caesareanbirth.org)	General	General	Thank you for this opportunity to comment during the Draft Scope consultation.	Thank you for your comment.
58	SH	Christian Medical Fellowship			Antenatal care will signpost to UK NSC fetal anomaly screening programme. This will include non-invasive prenatal testing (NIPT) of maternal blood for those mothers deemed to be at significant risk of having a child affected by trisomy (Down, Edwards or Patau syndromes). A positive NIPT screening result, followed by a diagnostic invasive test that confirms trisomy, would enable parents to prepare for the arrival of a child with special needs. The availability of time for reflection, qualified counselling and support, written and online resources and the opportunity to meet with parents of children with trisomy-related disabilities, and the children themselves, have been shown to be helpful in this, and we urge that this be reflected in the new guidelines. We do have a number of concerns for mothers and their partners:	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.

					• Increased anxiety for those whose risk levels, following existing initial screening tests, are considered just below the threshold level and who would not therefore 'qualify' for the new, more sensitive test. • The public misconception that NIPT is a 'diagnostic' test, on a par with invasive testing, not a screening test that would need to be followed by a diagnostic invasive procedure. Research has found that in over half of discussions, health care providers did not clarify the fact that screening is not diagnostic, and guidelines should emphasise the importance of clarity of communication in this. • Increased sense of 'tentativeness' in pregnancy – the mother is wary of committing, emotionally or relationally, to her unborn child lest the baby be shown by tests to carry an abnormality. The provision of sensitive, non-directive counselling, we suggest, should form part of standard procedure in the guidelines • Increased anxiety and uncertainty for women confronted by ambiguous results. Since an outcome of Down Syndrome represents a spectrum of disability, it is almost impossible to predict the implications for a particular child. The opportunity to meet with parents, siblings and the children themselves who are affected by trisomy syndromes, particularly Down Syndrome, we believe could go a long way towards reducing such fears and anxieties and provide an essential period of 'pause for thought' in place of rushing to a decision to terminate the pregnancy – a decision that might later be regretted. We are concerned about guidelines that might appear to reinforce the notion that children with chromosomal abnormalities (and thereby special needs) should be 'screened out' and destroyed. • Increased likelihood of some women making choices they later regret. A British Parliamentary Inquiry into abortion on the grounds of disability concluded that: '...the studies have all found that around 20% of women, between one and two years after an abortion for fetal abnormality, have a psychiatric condition, usually a complicated grief reaction, a depressive disorder or post-traumatic stress disorder.'[1] Signposting this possible long term outcome should be routine and included in guidelines. The availability of perinatal palliative care would encourage a higher proportion of pregnant women carrying a baby with a trisomy disorder to continue their pregnancies and avoid many of the mental disorders associated with regret. In one	

					British study, when parents were offered perinatal hospice as an option, 40% chose to continue with their pregnancies.[2] The comparative figure in US studies was between 75% and 85%.[3] • Guidelines should extend to the private sphere. As awareness of the test increases, and its cost comes down, then many pregnant women will seek to access the test privately. As things stand, they may not receive pre-test information and counselling. They will receive results outlining all manner of variable predictive risks faced by their babies, but will not have the context in which to discuss, assess and weigh the relevance of those results. This will increase anxiety further and make abortion a more likely outcome, sometimes without evidence of trisomy. • The routinisation and ease of accessing the tests are likely to lead to the general perception that it is a 'duty' to test rather than an option. Evidence from the Parliamentary Inquiry reflected this concern.[4] The test can also be used to determine the sex of the baby. The International BioethicsCommittee of UNESCO (IBC), sounding their concerns over the test, has said that: 'Another risk lies in the cultural prejudices of preferring a child of the male sex, the sex of the baby being one of the characteristics that can obviously be discovered by NIPT. As this test can be carried out at a very early stage of the pregnancy it would be difficult, even impossible for doctors to forbid the communicating of sex to the parents, and especially at a time when many countries have liberalised abortion. This could lead to a selection based on sex, which is against ethical values of equality and non-discrimination.'[5] Guidelines should encourage health professionals NOT to be drawn into giving information beyond the intention of the test.	

59	SH	Christian Medical Fellowship			We are also concerned about the implications for healthcare staff of implementing NIPT: The same technology that allows NIPT to detect trisomy also detects other genetic features, including gender, and will in time permit the detection of a wide range of genetic 'conditions' and predispositions. Increasingly widespread use of NIPT to analyse more and more genetic features up to the entire genome would mean the complexity of data would lead to a significant increase of false-positives, requiring confirmation by invasive tests of abnormalities whose relevance or significance is little known or not known at all. This uncertainty will lead many parents to not take any risk, with the resulting paradox: the number of invasive diagnostics would rise because of the use of the new test that should precisely be diminishing the use of invasive diagnostics. That increase in the number of invasive tests would also lead to an increase in the number of unintended miscarriages, often of normal fetuses. Increased rate of discovery of babies affected by Down Syndrome and other trisomies and, if current trends continue, overall increase in abortion numbers leading to a projected decline of 13% reported live births of babies with Down, Patau and Edwards Syndromes.[6] Healthcare professionals would be enabling a kind of informal eugenics, which would raise issues of conscience for many. Ground E of the Abortion Act does not specify what amounts to 'serious handicap'. In practice it is left to individual clinicians to 'interpret' the results of screening tests to parents and to inform them of likely implications. There will be many clinicians who do not believe that Down Syndrome represents a 'serious handicap'. There is potential for significant differences (and even conflict) between doctors as to which disabilities fall within the scope of the law and which do not. Clearer guidelines will be needed for doctors, particularly when they find themselves in such a situation late in a pregnancy, at a stage when the fetus is potentially viable. A culture shift among healthcare professionals is required. At present, subtle or direct pressure may be placed on parents who decide not to abort their child.[7] Some parents have already been made to feel that to bring into the world a child with known disability is somehow irresponsible and blameworthy,[8] a precedent that suggests that this trend will worsen. CMF supports the recommendations of the Parliamentary Inquiry into Abortion on the Grounds of Disability (2013)[9] that include: 'Guidelines for the medical profession should include training for obstetricians, fetal medicine specialists and midwives on the practical realities of the lives of children living with the different conditions which are screened for through ante-natal tests.'	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.

					Following Montgomery v Lanarkshire Health Board[10] the requirement upon doctors, as part of the consent process, to inform patients about risk associated with any procedure, or its alternatives, has been enhanced. The risks of false positive and inconclusive outcomes must be explained. The information provided should, for example, include: 'an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, or the risk of failure; or harm associated with options for treatment. The patient should be given time to ask questions. The GMC and the courts expect patients to be given all information material to their decision, with the proviso that it would not cause the patient serious harm'.[11] This sets the bar higher than the previous Bolam test and failure to comply risks legal action	

60	SH	Christian Medical Fellowship			We are concerned that the provision of information and counselling is presently unsatisfactory: Evidence from the Parliamentary Inquiry, already mentioned, suggests that healthcare professionals tend to assume women will participate in screening and that little attention is given to explaining the purpose or possible outcomes and options. In one study in a London teaching hospital, 27% of women did not know that they had received blood tests during pregnancy to detect spina bifida.[12] As the number of available genetic tests increases, so does the problem of providing suitable and sufficient pre-test information and counselling. Yet this is surely essential if consent is to be fully informed. Screening tests come with the aura of medical authority and respectability; to decline them may seem to be 'going against medical advice'. US Obstetrics and Gynaecology research found that the average time provided by healthcare providers to prenatal genetic screening counselling amounts to just 1.5 minutes, and does not adhere to College recommendations.[13] False-positive rates were seldom discussed and in half of the conversations between providers and parents, it was not made clear that prenatal genetic screening is not a diagnostic test. Cursory explanations and inadequate information undermine the integrity of consent in any healthcare setting.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP). Whilst a comment on antenatal care in USA is interesting, the organisation and provision of care in the UK is very different and is not comparable.
61	SH	Christian Medical Fellowship			In the UK Parliamentary Inquiry into Abortion on the Grounds of Disability, a 'considerable number of witnesses reported from their experience that after the discovery of a fetal disability, the presumption of the medical profession was that parents would opt for abortion'.[14] 'Parents can find themselves given only a leaflet on abortion and plenty of support or advice on having an abortion rather than a support package and/or information specific to the condition diagnosed.'[15] We support the recommendations of the Parliamentary Inquiry that 'It should be best practice that parents are provided with practical and balanced information as soon as possible after discovery of a fetal disability and before leaving hospital so that they can make an informed choice. This should include leaflets or other information written by relevant disability groups. Parents should be offered contact with families with a child with a similar diagnosis without delay' and that 'following a prenatal discovery of a fetal disability, parents should be encouraged and supported to consider adoption for their child as one of the options available to	Thank you for your comment. This guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline.

					them. Literature distributed by patient interest groups to couples should promote adoption as a positive option'.[16]	
62	SH	Christian Medical Fellowship	5	9	Information and support for women and their families: When pregnancy is confirmed, non-directive information about all screening tests should be made available. The distinction should be drawn between those tests that carry treatment options and those where the only available 'treatment' would be the termination of the pregnancy. It should not be assumed that a woman wishes to undergo every test. Time and trained pre-natal counsellors must be available so that women and their partners can understand their options and related risks, and make fully informed decisions. The culture in obstetric departments must change to one where the woman and her partner can comfortably refuse screening without experiencing a negative attitude in response. It must be made clear before taking the test that NIPT is not a diagnostic test, but a screening test and confirmatory invasive procedures may be necessary. If the result of any screening test, including NIPT (and any subsequent invasive test), suggests that the baby may have Down Syndrome or another trisomy, then parents should be offered the option to meet others who have first-hand experience of the condition or disability in question. This includes affected patients and their families, disability-specific support groups, healthcare professionals caring for babies, children and adults with the relevant condition. There should be counselling and support offered and available for those who choose an abortion on the grounds of disability both before and after abortion. For parents who choose to continue with their pregnancy, there needs to be improved, positive and consistent care and support from across the medical profession. As stated above, over time it is likely that those purchasing NIPT privately will be	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.

					given a mass of information outlining all manner of variable predictive risks faced by their babies. Anxiety levels are likely to rise and the experience of pregnancy become yet more tentative. Pregnant women and their partners will need help to understand, weigh and respond to the information they have been given and the burden of this is likely to be felt by NHS workers. Whatever information, genetic or otherwise, that NIPT brings to light, should be used only to enable medical staff, parents and other family members to be better prepared for the arrival of the new baby or to enable therapeutic interventions (medical or surgical) to improve the baby's health before birth or in the perinatal period. Waiting for a child, that is known to be impaired to be born can be a distressing and anxiety-ridden experience. There is much to be said for not knowing in advance, so that parents can give themselves to loving the mysterious gift that is not yet 'unwrapped'.	
63	SH	CMV Action	1	26	Excellent antenatal care is also important to reduce avoidable pressures on postnatal care. It will be important for the committee to consider evidence on what is important to women and their families in hindsight looking back at their pregnancy as well as what they value at the time.	Thank you for your comment. We agree it will be important to consider evidence about the views and experiences of women and their families, including those expressed following the birth. However, this is beyond the scope of this guideline.

64	SH	CMV Action	3	15-16	Signposting to conditions screened for will not be sufficient to help women reduce their risks of infection in pregnancy because many infectious diseases do not meet the criteria for screening. One issue with the last guideline is that it highlighted that CMV should not be screened for but did not have any further signposting or advice for professionals about other aspects of management. As an organisation we have received an increase in calls to our helpline over the past 10 years from terrified women who have been diagnosed with CMV infection in pregnancy following investigations but then received confusing, conflicting or incorrect information from health professionals. RCOG have recently reviewed evidence on treating CMV infection in pregnancy and include advice on diagnosis and management in their Scientific Impact Paper No. 56 'Congenital Cytomegalovirus Infection. It would be very helpful if the new guideline could signpost professionals to this document as the best currently available review of evidence on CMV infection in pregnancy. Reference: Congenital Cytomegalovirus Infection: Update on Treatment, Scientific Impact Paper No. 56, RCOG November 2017.	Thank you for your comment. We will be covering information and support needs in the guideline and CMV infection will be considered by the committee as a specific aspect to signpost during the development of recommendations as no further evidence reviews will be undertaken to address this key area and the guideline will refer to existing relevant NHS guidance.

65	SH	CMV Action	4	17	Equality Impact Assessment - Some groups of women may be at higher risk of pregnancy infections than the general population of pregnant women and organisations other than the NHS may have a role to play in supporting a safe and healthy pregnancy. For example – some studies have shown that CMV seronegative women who have frequent contact with small children in childcare settings have an increased risk of acquiring CMV compared with seronegative women who don't have this contact with small children. This effect is strongest for women with their own children, but is also found in pregnant women who care for young children in child care settings. Additionally women from some socioeconomic groups are at increased risk of infection. It would be useful if the reviewer could consider this when reviewing evidence as highlighting findings in the guideline could prompt action from employers and organisations representing these groups. References: Adler et. al (1989). Cytomegalovirus and child day care. Evidence for an increased infection rate among day-care workers. N Engl J Med. 1989 Nov 9;321(19):1290-6. Adler, S.P., Finney, J.D., Anne Marie Manganello, R.N., and Best, A.M. (2004) Prevention of child-to-mother transmission of cytomegalovirus among pregnant women. 10.1016/j.jpeds.2004.05.041 Adler, S.P., Nigro, G. (2013) 'Prevention of Maternal-Fetal Transmission of Cytomegalovirus', Clinical Infectious Diseases, Vol 57, p189–192. Joseph et al (2006). Cytomegalovirus as an occupational risk in daycare educators. Paediatr Child Health. 2006 Sep;11(7):401-7. Pass et al (1990). Increased rate of cytomegalovirus infection among day care center workers. Pediatr Infect Dis J. 1990 Jul;9(7):465-70. Yinon, Y., Farine, D., Yudin, M.H., (2010) 'Cytomegalovirus in pregnancy', Journal of Obstetrics and Gynecology Canada, Vol 240, p388-354.Pass et al. Group day care and cytomegaloviral infections of mothers and children. Rev Infect Dis. 1986 Jul-Aug;8(4):599-605.	Thank you for your comment and for your suggested references. However we do not agree that that this is an equalities issue as any woman could have a child in a nursery and thus access to other children. The potential equalities issue is that women who are born in LMIC may be at higher risk of being CMV seronegative. This is an issue for the NSC to consider regarding their review of screening for CMV.

66	SH	CMV Action	5	12	RCOG scientific impact paper mentioned in comment 2 will be relevant to this area	Thank you for your comment. We will be covering information and support needs in the guideline and CMV infection will be considered by the committee as a specific aspect to signpost during the development of recommendations as no further evidence reviews will be undertaken to address this key area and the guideline will refer to existing relevant NHS guidance.
67	SH	CMV Action	5	14	Considerations of risks related to working with small children will be relevant in this area – see comment 3	Thank you for your comment and for your suggested references. However we do not agree that that this is an equalities issue as any woman could have a child in a nursery and thus access to other children. The potential equalities issue is that women who are born in LMIC may be at higher risk of being CMV seronegative. This is an issue for the NSC to consider regarding their review of screening for CMV.

68	SH	CMV Action	8	25	A CMV Action project commissioned from York Health Economics Consortium to estimate the cost of congenital CMV infection in the UK has recently been completed, putting the cost at around £700m per year. This evidence will be published during the timeframe of this guideline review and we would be happy to make the analysis available to the Committee. References: York Health Economics Consortium: The Economic Cost of Congenital CMV in the UK (abstract accepted for presentation at the European Congenital CMV Initiative conference May 2018). YHEC compiled estimates of incidence and costs from the published literature, using UK sources where possible and developed a model to aggregate a snapshot of the estimated direct, indirect and personal costs in the year 2016 (the most recent complete single year when the model was developed).	Thank you for your comment and for the offer of data from your ongoing project. This is an issue for NSC to include in the decision regarding their review of screening for CMV.
69	SH	CMV Action	9	7to8	We have grey evidence that we can contribute to these areas of investigation. These include a ComRes survey of over 1000 British women's attitudes towards CMV prevention and qualitative data from interviews and focus groups run as part of an NIHR funded feasibility study, called RACE-FIT, currently underway to develop and test a CMV education intervention that could be delivered in the NHS. To summarise this evidence, pregnant women know very little about CMV, but once they are given some information about it, women felt strongly that they should routinely be given this information during pregnancy. Particularly, because the risk of acquiring CMV during pregnancy is modifiable. Families affected by congenital CMV, express dismay and anger that they were not given information about CMV whilst pregnant, so they had no opportunity to prevent this infection. The RACE-FIT study will report in 2019 and aims provide additional evidence that information about CMV can be feasibly provided within the NHS in order to modify behaviours associated with increased risk of CMV acquisition in pregnancy. References: British women's attitudes towards CMV prevention: ComRes interviewed 1,008 British women aged 18-44 online between 28th- 30th March 2014. Data were weighted to be representative of all women aged 18-44 in GB by age and region. ComRes is a member of the British Polling Council and abides by its rules. Full data tables are available on the ComRes website – www.comres.co.uk Rethinking Antenatal Education Interventions: Using theories of behaviour change to inform interventions to reduce infections in pregnancy: Abstract accepted for	Thank you for your comment. The systematic review on information and support for women and their families will examine what information women want and need with regard to reducing the risk of viral infections as parvovirus, chickenpox and CMV. We will be covering information and support needs in the guideline and CMV, parvovirus and chickenpox will be considered by the committee as specific aspects to signpost during the development of recommendations as no further evidence reviews will be undertaken to address this key area and the guideline will refer to

					presentation at DHP Annual Conference, Sept 2018 RACE FIT study: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/race-fit-phase-i/	existing relevant NHS guidance.
70	SH	CMV Action	11	1.4	We have grey evidence that we can contribute to these areas of investigation. These include formative research on risk reduction messaging from the US and qualitative data from focus groups and interviews run as part of an NIHR funded feasibility study currently underway to develop and test a CMV education intervention that could be delivered in the NHS.	Thank you for your comment and for the information about your research. However, no further evidence reviews will be undertaken to address this key area and the guideline will refer to existing relevant NHS guidance.

71	SH	CMV Action	10	24-27	Since this is a new guideline it is not clear why evidence on reducing risks of infectious diseases in pregnancy will not be reviewed. In the absence of reviewing the evidence there isn't a rationale for including the specific conditions listed in the scope and not others. The CMV research network that comprises several paediatric infectious disease experts is not aware that the evidence on prevention interventions is any better for the conditions listed in the scope. Also far more harm is caused by other infectious diseases - for example CMV (~900 babies per year), parvovirus (~500 babies affected per year) or chickenpox (~250 babies affected per year) compared with listeriosis and other food-borne infections (<30 per year).. This information isn't sufficiently covered in other resources. Existing NHS guidance on reducing risks of infectious disease transmission in pregnancy is limited and health professional knowledge of risks and transmission routes is patchy. In order to improve delivery of risk reduction advice across infectious diseases and outcomes for women and infants we recommend that the guideline development includes the question: what interventions are effective in reducing risks of acquisition of infectious diseases in pregnancy? Evidence may be lacking in a number of areas but a clear message on this from the Committee would help to improve design of future research and focus professional education. To support this, we can share a very recent systematic literature review of studies that assessed the effectiveness of hygiene-based educational interventions to reduce the acquisition of CMV in pregnancy undertaken as part of an NIHR funded study (not yet published but expected during the timescale of guideline development). None of the studies identified were UK based and a number had methodological weaknesses. To address this, an NIHR funded feasibility study is underway to develop an education intervention aimed at reducing transmission of CMV relevant to the NHS and to determine the feasibility of a definitive RCT that assesses the effectiveness of this intervention. Further evidence may become available during the development timescale and we would like to keep the Committee updated with any findings of interest (negative or positive): please contact Dr Chrissie Jones for more information: c.e.jones@soton.ac.uk, https://www.southampton.ac.uk/medicine/about/staff/cej1e16.page	Thank you for your comment. We will be covering information and support needs in the guideline and CMV, parvovirus and chickenpox will be considered by the committee as specific aspects to signpost during the development of recommendations as no further evidence reviews will be undertaken to address this key area and the guideline will refer to existing relevant NHS guidance.

72	SH	Committee of the Midwifery Forum of the Royal College of Nursing	6	42064	If these topics are to be excluded from the new guideline there needs to be clear signposting to where this information can be found for both health professionals and women	Thank you for your comment. Whilst these are common areas of concern for many pregnant women, the scoping group agreed that that they are covered by relevant NHS guidance.
73	SH	Committee of the Midwifery Forum of the Royal College of Nursing	9	14 1.6	Antenatal classes and groups: may need to consider that not many women attend and some Trusts no longer provide these. Many women seem to get most of their information from online sources.	Thank you for your comment and the committee will consider this during protocol development.
74	SH	Committee of the Midwifery Forum of the Royal College of Nursing	11	20, 21	Given the prevalence of new mental health problems in pregnancy is it sufficient to refer to another guideline without also including some information and guidance?	Thank you for your comment. We will signpost to the recommendations from CG 92 in this guideline. For further details, please see: https://www.nice.org.uk/guidance/cg192.
75	SH	Committee of the Midwifery Forum of the Royal College of Nursing	General	General	How will diversity and health needs be addressed in the new guideline?	Thank you for your comment. An equality impact assessment has been carried out during scoping. The guideline will look at inequalities relating to disability. In terms of health needs, the guideline is applicable to all women including those with maternal conditions as they continue to need normal antenatal care alongside specialised care. Note that

						specialised care is not covered in this guideline.
76	SH	Committee of the Midwifery Forum of the Royal College of Nursing	General	General	While this guideline is for uncomplicated pregnancies, there is no mention of termination of pregnancy. Given that some initially uncomplicated pregnancies may end in termination, should this be mentioned?	Thank you for your comment, the NICE guideline on Termination of Pregnancy is currently in development and therefore is outside of the scope for this guideline. For further information, please see: https://www.nice.org.uk/guidance/indevelopment/gid-ng10058
77	SH	Committee of the Midwifery Forum of the Royal College of Nursing	General	General	There is almost no mention of the woman's partner in the document. How will this deficit be addressed in the guideline?	Thank you for your comment. The guideline is proposing to look at information that is valued by women and their partners and families, and in light of stakeholder comments we are now also including an evidence review question on how to involve partners during antenatal care.
78	SH	Committee of the Midwifery Forum of the Royal College of Nursing	General	General	How will the impact of the changes to the guideline be assessed?	Thank you for your comment. For every recommendation, the committee will consider their likely impact on practice. NICE will also conduct cost-impact analysis to establish the

						resource impact of recommendations.
79	SH	[csections.org]	General	Qu. 1 Above	1) Which interventions or forms of practice might result in cost saving recommendations if included in the guideline? At all points during the antenatal period, assumptions should not be made about a woman's preferred mode of delivery and in particular no judgements made about her mental health based on her preferences. Referring a woman for mental health assessments when she requests a caesarean is unnecessary for those making informed decisions in favour of a caesarean. With this in mind duplication of effort can be avoided (reducing unnecessary cost) by scheduling appointments with obstetricians rather than midwives for those women requesting a caesarean and omitting referrals to mental health specialists. The NICE guideline (CG132) does not recommend all women meet with a mental health professional when requesting a caesarean. However, some Trusts have begun to stipulate this and this is driving costs up unnecessarily. Informed choice in favour of a planned caesarean has been an accepted part of NICE recommendations since 2011 and yet we are still seeing Trusts create artificial caesarean rate targets, we are still seeing women embarrassed and criticised for valid choices. Education about these choices needs to be built into the Antenatal guideline to ensure that Trusts accommodate this informed group of women from the outset, not leaving them until week 36 before they are allowed to raise the question of a caesarean delivery. Facilitating informed choice for those women wishing to plan a caesarean could actually cut costs. A significant percentage of UK births involve some form of intervention - over 55% of UK births. [RCOG press release: Report Highlights variation in maternity care across England., March] and allowing 'low risk' women requesting a planned caesarean, with its associated cost level, can be removed	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

					from the lottery of vaginal births whose costs can easily spiral from standard interventions such as induction, anaesthesia etc.	

80	SH	[csections.org]	General	Qu. 2 above	1. 2) Are hospital maternity dashboards a helpful or harmful influence on antenatal care? Csections.org recognise monitoring of performance on measures such as those identified on a maternity dashboard have significant value in safeguarding clinical practise and improving maternity care. However, we strongly resist the idea that Trusts should be including caesarean rate targets within their dashboard. As informed choice, numbers of older mothers and numbers of obese mothers steadily increase it is impossible to set targets other than by using 'cost to the Trust' as the factor. Three key points emphasise the need to reject such a target from the maternity dashboard: The World Health Organisation retracted their recommendation on CS rates in 2009 because they acknowledged there was no clinical evidence to support an ideal rate. Their handbook now states there is "no empirical evidence for an optimum percentage", an "optimum rate is unknown," and world regions may now "set their own standards". A planned caesarean in the absence of any medical need has no greater risk outcomes than a vaginal birth. [J. Svigos, 'Commentary on 'Maternal Outcomes Associated with Planned Vaginal Versus Planned Primary Cesarean Delivery. F1000: "Changes Clinical Practice"' Medscape Today] Indeed, a Swedish study reveals that, when the two types of caesarean are separated (planned versus emergency), the death rates for vaginal birth and planned caesarean are not only very low but crucially, almost identical (5 and 4 in 10,000 respectively). Only unplanned caesareans show a higher rate of risk of death (29 in 10,000) K. Kallen, P.O. Olausson, 'Neonatal Mortality for Low-Risk Women by Method of Delivery' Letters in BIRTH, 34/1 (2007) 99-100]	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

81	SH	[csections.org]			The cost of a planned caesarean in the absence of medical need is actually the same or less than a medicalised vaginal birth that includes induction or anaesthetic pain relief. [B.W. Bost, 'Cesarean delivery on demand: what will it cost?' American Journal of Obstetrics and Gynecology, 188/6 (2003) 1418-21] and we know that a significant percentage of UK births involve some form of interventions - 55% of UK births [RCOG press release: Report Highlights variation in maternity care across England., March 2016 https://www.rcog.org.uk/en/news/rcog-press-release-report-highlights-variation-in-maternity-care-across-england/] By using cost to define a Trusts target CS rate, they cannot take into account the wishes of the women they treat nor have their welfare at the heart of the decision-making process. CS rates in the dashboard should be removed. Women should not face a postcode lottery for their preferred birth mode. Nor should they be subjected to the bias of Trusts based on unjustifiable assumptions about cost of planned CS versus medicalise vaginal births.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

82	SH	[csections.org]	General	Qu. 3 above	3) Post Montgomery, and with women increasingly demanding full disclosure of both delivery mode risks, should caesarean birth (Planning mode of birth) be included in this antenatal update/pathway? Is it appropriate to focus solely on 'Planning place of birth'? It is our opinion that caesarean birth should absolutely be included as part of the pathway, even for women in 'low risk' pregnancies. UK statistics show that there is a good chance, even with a 'low risk' pregnancy, that over a quarter of women will have a caesarean. Not only is it important when looking at emotional outcomes for unplanned caesareans that women have understood and discussed the procedure [J. Lally, M. Murtagh, S. Macphail et al, 'More in Hope Than Expectation: A Systematic Review of Women's Expectations and Experience of Pain Relief in Labour' BMC Medicine, (2008) 6:7doi:10.1186/1741-7015-6-7] but that they have discussed the pathway opportunities open to them with regard moving over to a caesarean delivery in preference for example to induction at 41 weeks or to the use of forceps etc. In these latter examples women should be made fully aware during the antenatal period that there is a clear pathway for a prophylactic caesarean. All too often they have been given no advice on this and the risks of induction (and associated cascade of intervention) and risks with instrumental deliveries not adequately discussed for 'fear of frightening them'. As my colleague Pauline McDonald eloquently points out "If NICE is not convinced by me, may I suggest canvassing the views of litigation specialists, and ascertaining how many women with adverse outcomes began their pathway labelled "low risk" or "uncomplicated"? I understand that NICE does not include NHS Resolution (formerly NHSLA) data in its economic analysis, but I feel it's important to highlight the huge cost of obstetrics litigation here (including women with serious pelvic floor injuries, many of whom say they were 'never told about the risks')." Please also note, that in our experience, women report that practitioners are very willing to discuss home birth as a valid birth place choice, but not caesarean delivery even though the incidence of this is actually higher than home births. This bias must be brought under control.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

83	SH	[csections.org]	9	7	1.1 What information do women value as part of their antenatal care? Some women want to make an informed decision about the way they would like to try to give birth. Csections.org is frequently contacted by women desperately trying to understand caesarean birth for example - ironically, usually because they have been told they need one but don't feel they have been given enough information about the procedure they have been told they 'need'. (Rarely do these enquiries come from women requesting a caesarean in the absence of any medical need). This assumption that we should not 'scare women' by talking about interventions is disrespectful and damaging. In the case of caesarean birth specifically, while it is more often a needed intervention, handled correctly it can be presented with a very positive message - In certain situations, it is the most reliable way for the baby to safely arrive. With this in mind, caesarean birth needs to be given just as much time and attention as vaginal birth. A simple example is that techniques taught to women to cope with the stress and exhaustion of vaginal birth are equally useful to women preparing for and experiencing caesarean birth – overtly sign-posting this during antenatal education is useful, particularly for those women hoping to avoid a caesarean. Research clearly shows that realistic expectations significantly improves emotional outcomes for women, significantly reduce fear and postnatal trauma and subsequent difficulties with bonding. [J. Lally, M. Murtagh, S. Macphail et al, 'More in Hope Than Expectation: A Systematic Review of Women's Expectations and Experience of Pain Relief in Labour' BMC Medicine, (2008) 6:7doi:10.1186/1741-7015-6-7] Providing women with a feeling of control is crucial in emotional outcomes of births that have not gone exactly to plan. The antenatal care process is the ideal place to address this with women, particularly given the ever reducing number of women that choose to attend optional antenatal classes.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
84	SH	[csections.org]			Given that we are told that more women are requesting caesareans and given that we know more women are wanting to make an informed choice about their birth mode, it is essential that the NHS begin accurately collating information about maternal request caesareans - the rates of and outcomes for both mother and baby. This is just the sort of information that women want during the antenatal period in order to make truly informed decisions.	Thank you for your comment. The risks and benefits of planned caesarean sections as part of maternal requests are covered by the update of CG132

						https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
85	SH	[csections.org]	9	8	1.2 What information do partners and families value as part of antenatal care? It is not uncommon for Csections.org to be contacted by a birth partner, asking for information about caesarean birth. In general, this tends to be because their partner is distressed at having been told they have to have a caesarean. In many cases they are looking for support on how to avoid this. But this rather proves the point that caesarean delivery must be given equal respect as a birth mode. Women and their partners need to know about this possibility. In particular they need to know how they can prepare their home and family for this eventuality but also what the things are that they can do postnatally to cope with the after effects – emotional and physical – of caesarean delivery. https://www.amazon.co.uk/Caesarean-Birth-Positive-Approach-Preparation/dp/0956848001/ref=as_sl_pc_qf_sp_asin_til?tag=tiskimocom-21&linkCode=w00&linkId=&creativeASIN=0956848001 For birth partners and family members, it is crucial they understand the differences a caesarean can make to recovery. Where an unplanned emergency caesarean has occurred there can be additional factors to contend with. All too often antenatal education deals with vaginal birth only. A mother may read a little more broadly but many partners do not and so the only information they have is from the antenatal classes they 'might' attend or the mother (who may be ignoring caesarean birth) and if these routes fail to discuss caesarean birth, the potential for trauma and misunderstanding is tremendous.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

86	SH	[csections.org]	9	10	1.3 When should information be given during antenatal care? This must surely be tailored to the individual's needs. Some women want lots of information, others less. Having spoken with many practitioners over the years, midwives in particular, it appears to unfortunately be the case that there is an assumption that women find caesarean birth scary so it is hardly touched on during the antenatal period. To concentrate solely on vaginal birth and portray a caesarean as a last resort is all too often the case and this does a major dis-service to women. From the outset women are afraid of this mode of birth. Rather, information about caesarean birth needs to be offered to all women at some point in their antenatal period (not right at the end) and discussed in positive terms as a valid delivery mode. A timetable of discussion topics should be presented at the beginning of the antenatal period and the woman given the opportunity to participate in the progression of that discussion over time. Caesarean birth should be listed alongside every other aspect of antenatal education and where women are reluctant to talk about it, should be encouraged to understand that this is a possible outcome of their birth and it can help to understand a little of what is involved. Reassuring them that they do not need to see images of scars or of surgery is vital.	Thank you for your comment. The points you make about information provision during antenatal care will be considered by the committee during the development of the evidence reviews on information and support.
87	SH	[csections.org]	9	11	1.4 How should information be delivered during antenatal care? As above, where women are reluctant to talk about caesarean birth, they should be encouraged to understand that it is a possible outcome of their birth and it can help to understand a little of what is involved. Positive messages about caesarean birth are crucial and reassuring them they do not need to see images of scars or of surgery is vital.	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.

88	SH	[csections.org]	9	14	1.6 How effective are antenatal classes and groups? It is essential that antenatal classes provide balanced information about ALL modes and places of delivery. Classes which are focussed on a particular mode or place of delivery should make it absolutely clear to women that they are not covering ALL possibilities. Ideally, they should also make it absolutely clear that their classes do not guarantee the outcome being emphasised. This may seem obvious but you only have to look at the majority of birth plans to realise that many women do not understand that their situation may change so radically during birth that pain relief and caesarean delivery are actually factors they should have an opinion on – beyond saying “I don’t want…” Half of UK women surveyed in 2015 report changing their pain management plans during labour. NHS, ‘2015 survey of women’s experiences of maternity care, Statistical release’, NHS Patient Survey Programme, Dec 2015, http://www.cqc.org.uk/content/maternity-services-survey-2015 Antenatal classes and groups are only as good as the agenda of the practitioner delivering it. Unfortunately bias is often allowed into these groups and women are left ill-informed and wide open for mental health, breastfeeding and bonding difficulties afterwards partially as a result of unrealistic expectations prior to the birth – expectations guided by those meant to be helping them. . [J. Lally, M. Murtagh, S. Macphail et al, ‘More in Hope Than Expectation: A Systematic Review of Women's Expectations and Experience of Pain Relief in Labour’ BMC Medicine, (2008) 6:7doi:10.1186/1741-7015-6-7]	Thank you for your comment. The point you make will be considered by the committee during the development of the protocol on the evidence review question on effectiveness of antenatal classes .

89	SH	[csections.org]	9	17	2.2 What appointment timing is effective and safe in delivering antenatal care? Women are frequently told that they cannot request a caesarean until wk 36. This is far too late. Women making an informed choice for either mode of delivery should be able to make that decision at ANY point in the antenatal period. Women stating a preference for a vaginal birth can do so at any point, women wishing to request a caesarean should be afforded the same right. The stress associated with not knowing whether or not a request is going to be granted, for those women wanting or needing a planned caesarean, is unacceptable and unnecessary. Ideally, women having a planned caesarean should have an agreed delivery date, one which is not subject to change. Please note this recommendation from the Royal College of Anaesthetists during the 2012/13 NICE Caesarean Section Quality Standard Consultation: “The OAA feels strongly that women undergoing planned Caesarean section should have their delivery scheduled on a dedicated and time protected elective Caesarean section list. In the majority of hospitals (OAA survey data evidence), elective procedures are carried out in an ad-hoc manner and are frequently interrupted by emergency Caesarean sections, other operative deliveries or obstetric procedures in theatre, or by obstetric, midwifery or anaesthetic staff becoming unavailable because of unforeseen demands on the labour ward. The consequence is that elective sections are often postponed to the next working day or later, despite the mother having been fully prepared and fasted, and often having placed other children into childcare arrangements for the day (audit data from Nottingham and other hospitals available to support this). No other elective surgery in the NHS works to this haphazard model.”	Thank you for your comment. The risks and benefits of planned caesarean sections as a result of maternal requests are likely to be covered by the update of CG132 https://www.nice.org.uk/guidance/CG132 and this guideline will signpost to the recommendations therein developed.
90	SH	Department of Health	General	General	I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation.	Thank you for your comment.

91	SH	Don't Screen Us Out	3	13	The use of the word 'disorder' is not helpful here, the word 'conditions' or 'anomalies' would be better. This should be changed and the use of language throughout considered re Public Health Equality Duty (see comment 2)	Thank you for your comment. We have revised 'disorder' to 'conditions'
92	SH	Don't Screen Us Out	4 & General	16 & General	It must be made clear that guidance such as CG62 must be reviewed to conform with Public Health equality duties. For example, when professionals use terms such as disorder/abnormality/risk, these are insensitive and can be considered offensive by people living with such conditions.	Thank you for your comment. The language used in the recommendations will be carefully considered by the committee. Please also note that the draft guideline will published for consultation among stakeholders, which will provide an additional safeguard in relation to the final wording of the recommendations.
93	SH	Don't Screen Us Out	5	9	Consideration must be made of information for women continuing a pregnancy following a high chance or more definitive screening result. They will require ongoing and appropriate support to maintain their wellbeing in pregnancy. There is currently no protocol for such support, and this has been a well-documented problem for many women. Nuffield Bioethics Council have now recommended the development of a guideline such as this for those continuing pregnancy after high chance/definitive antenatal test result. Provision of that guideline will become even more relevant as additional conditions are identified through exome and whole genome screening in future. This review is timely, as a 3-year evaluation of new genomic screening testing (Non-Invasive Prenatal Testing) is about to begin and guidance needs to evolve accordingly.	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline.

94	SH	Don't Screen Us Out	5	9	According to the last review of guidance in 2011 "The inconsistencies between the UK National Screening Committee standards for screening for Down's syndrome and fetal anomalies and the guideline recommendations will be taken into account in the next review of the guideline"	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
95	SH	Don't Screen Us Out	5	9	1) The draft scope must include review of guidance around the Fetal Anomaly scan. This information must be developed more fully in this review in order to ensure that: Individuals understand what the purpose of this scan is before choosing to undergo such screening. The issue of consent and information was brought into sharp focus by the landmark Montgomery Case (2015) on Informed Consent. Appropriate information (Montgomery Case (2015)) and support is offered when any conditions are detected.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
96	SH	Don't Screen Us Out	5 & General	9 & General	Since the last review, the landmark Montgomery Case (2015) on Informed Consent has taken place. Therefore, consideration of how this affects the information given to individuals when they are required to make decisions at this time.	Thank you for your comment. The point you make about the provision of information and informed consent will be considered during the development of the evidence review protocols for the questions on information and support for women and their families.
97	SH	Don't Screen Us Out	9 & General	3 & General	The draft scope must include be further developed to ensure that individuals are given the appropriate information to help with their decision making. The issue of consent and information was brought into sharp focus by the landmark Montgomery Case (2015) on Informed Consent.	Thank you for your comment. The point you make about the provision of information and informed consent will be considered during the development of

						the evidence review protocols for the questions on information and support for women and their families.
98	SH	Don't Screen Us Out	9	11	Consideration must be made as to how to sensitively deliver information to those with Additional Support Needs.	Thank you for your comment. The point you make about the provision of information and informed consent will be considered during the development of the evidence review protocols for the questions on information and support for women and their families.
99	SH	Don't Screen Us Out	11	32	There is no beneficial reason for uptake of screening to be a main consideration in the outcomes section, this should be removed for correctness.	Thank you for your comment. To clarify, uptake of screening is not described in the draft scope as a main outcome.

100	SH	Down Syndrome Research Foundation UK	4	21	It is important to consider how information is best presented to people with a whole range of cognitive abilities, including those with Down syndrome, who may have a mild to moderate learning disability. Elfrida Society have produced some excellent work in this area and should be consulted.	Thank you for your comment. NICE guidance on patient experience in adult NHS services (CG138) covers issues related to communication according to individual needs and consideration for individual's needs and circumstances (including disabilities) in general. We will signpost this in the guideline recommendations. The language used in the recommendations will be carefully considered by the committee. Please also note that the draft guideline will published for consultation among stakeholders, which will provide an additional safeguard in relation to the final wording of the recommendations. (added March 2019 for clarification following an enquiry)

101	SH	The Ups of Downs and Positive about Down syndrome	4 General	16 General	As above, CG62 has to be reviewed in accordance with equality guidance framework, for compliance (Public Health equality duties). Language must be sensitive to people with disability.	Thank you for your comment. NICE guidance on patient experience in adult NHS services (CG138) covers issues related to communication according to individual needs and consideration for individual's needs and circumstances (including disabilities) in general. We will signpost this in the guideline recommendations. The committee will consider adjusting language where necessary during the development of recommendations. (added March 2019 for clarification following an enquiry)
102	SH	Down Syndrome Research Foundation UK	5	24	A pregnancy with Down syndrome can be complicated or uncomplicated depending on any additional medical diagnoses. For ease of use it is important that there is one guideline that covers the antenatal period for a pregnancy with Down syndrome, and CG62, particularly as it is being renewed at this time, would be an ideal place to include a pathway for it.	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is

						not covered in this guideline.
103	SH	Down Syndrome Research Foundation UK	9	3	1) Two additional key questions should be asked: Are women making informed choices (as defined perhaps by Marteau et al, 2001, Making an Informed Choice "based on relevant knowledge, consistent with the decision-maker's values and behaviourally implemented") about uptake of screening blood tests, nuchal fold measurement, fetal anomaly scans and diagnostic tests? What type of decision aids, decision analysis tools, are helping/would help women to make informed decisions? What checks and balances exist to ensure informed choice is happening during the consent to screening process?	Thank you for your comment. The points you have made about women's informed choice during antenatal screening blood tests will be considered by the committee during the development of the evidence review protocols for information and support for women and their families.
104	SH	Down Syndrome Research Foundation UK	9	7	Evidence base on this issue: In light of the Montgomery judgement (2015), it is important to consider what information women might consider important to enable them to make decisions during antenatal care.	Thank you for your comment. The point you make about the provision of information and informed consent will be considered by the committee during the development of the evidence review protocols for information and support for women and their families.
105	SH	Down Syndrome Research Foundation UK	9	11	How unexpected information is delivered to women should also be considered. Results of an ultrasound, in the appointment by the sonographer? Results of blood tests/amnio or CVS by prearranged phone call, face to face etc? By a midwife/geneticist/obstetrician? Further what the follow up should be after unexpected information has been delivered, e.g. referral to outside agencies (how these are chosen/monitored),	Thank you for your comment. The point you make about the provision of information will be considered by the committee during the development of the

					timing of face to face appointment with Prenatal Diagnosis Department, and which leaflets/booklets/weblinks are appropriate to be offered at this time?	evidence review protocols for information and support for women and their families.
106	SH	Down Syndrome Research Foundation UK	9	22	Continuity of HCPs in pregnancies that are identified as higher chance for a condition (and flowing through to those with confirmed diagnoses) would be a better standard of care. Currently the constant change of HCPs in these cases mean women who would like to continue pregnancies are repeatedly offered terminations despite clear documentation in their notes to the contrary.	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline.
107	SH	Down Syndrome Research Foundation UK	9	12	In terms of peer support, it is very important to look at how or if these groups should be deemed suitable for referral by the NHS, whether they need regulation, if there is a feedback mechanism in place etc.	Thank you for your comment. The point you make is outside of the scope of NICE guidance to develop recommendations about the regulatory authority of the NHS.

108	SH	Down Syndrome Research Foundation UK	11	31	With the introduction of the new screening test for Down syndrome, and in the light of the Nuffield Council of Bioethics recommendations, it is important that the satisfaction of care of women who have received a high chance or a diagnosis of Down syndrome is considered. If there is a protocol for care of these women in place, then that is likely to increase satisfaction, as well as being consistent with the ethical delivery of prenatal testing and informed choice.	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline.
109	SH	Down Syndrome Research Foundation UK	11	32	In terms of uptake of prenatal screening for Down syndrome, it is important to take a multidimensional view of this. Not to look at numbers of uptake, but rather uptake in line with personal values, and awareness of uptake of screening e.g. many women are not aware that the 12 and 20 week scans can form part of a screen for Down syndrome, and just think of screening as blood tests.	Thank you for your comment. We anticipate that personal values and awareness about screening will be addressed in the questions on what information and support for women and their families.

110	SH	Down Syndrome Research Foundation UK	General	General	In line with the principles of non-discrimination, and the Equality Act (2010) any language in this guideline that references a pregnancy with Down syndrome, must be considered with people with Down syndrome in mind, so that it does not come across in a discriminatory fashion. For example, the use of the word 'risk' in reference to having a child with Down syndrome, can imply that having Down syndrome is intrinsically negative, or the use of the word 'disorder' that there is something inherently wrong with people who have Down syndrome.	Thank you for your comment. The language used in the recommendations will be carefully considered by the committee. Please also note that the draft guideline will published for consultation among stakeholders, which will provide an additional safeguard in relation to the final wording of the recommendations.
111	SH	Down Syndrome Research Foundation UK	General	General	You have asked "You must declare any links with, or funding from, the tobacco industry" but not if organisations and others have any links with, or funding from, the fertility or antenatal testing industry eg Iona or Harmony tests. Perhaps NICE might like to include that conflict of interest as particularly relevant to this guideline.	Thank you for your comment. Committee members are asked during recruitment and throughout the development of the guideline of any interests they may have with manufacturers of interventions relevant to the scope of the guideline and these are then managed in accordance with the NICE policy on declarations of interest.
112	SH	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	General	General	Flu vaccinations and the fact that midwives are ideally placed to give this as part of their antenatal care/ reviews	Thank you for your comment. An evidence review on flu vaccinations will not be conducted but this guideline will signpost to relevant NHS vaccination programmes.

113	SH	Fatherhood Institute	General	Fathers' impact prenatally and preconception – in relation to SMOKING	We note that smoking is not the topic of this guideline, but we think it should not go unremarked – and for this important reason: although a previous NICE guideline has recommended that pregnant women's partners be included in smoking referrals and education, the video resource commonly used to address smoking in the NHS is only targeted at the pregnant woman, and does not EVEN ONCE mention her partner. Nor are HCPs directed to engage with the partner.	Thank you for your comment. As part of the guideline development we cannot influence the content of an NHS video resouce.

114	SH	Fatherhood Institute	General	THREE OF SIX RECOMMENDATIONS FROM THE forthcoming Fatherhood Institute review of the UK literature (Nuffield Foundation funded) - *Who's the Daddy? British fathers in the antenatal period and at the birth*	RECOMMENDATION 1: TERMINOLOGY Although only a tiny minority (fewer than 1%) of the partners of pregnant women in the UK are not the biological father of the child, and although at least 95% of biological parents are in a relationship at the time of the birth, the term 'woman's partner' or 'mother's partner' (rather than 'father') is commonly used in maternity services. This defines the baby's father solely as a support-person and does not recognise his unique connections (both biological and social) to his infant. The term 'woman's partner' should be widely replaced by 'father/ woman's partner'. While inclusive, this acknowledges the father's distinctive role. In addition, the term 'parent' should not be used as a synonym for 'mother' but to describe mothers-and-fathers collectively: the use of the word 'parent/ parents' when only 'mother/ mothers' are meant, can cause confusion and mask the fact that fathers are not participating or being addressed. Referring to the 'mother' is absolutely justified in some circumstances – but in such cases the term 'mother' or 'pregnant woman' should be used, instead of 'parent'. RECOMMENDATION 2: REGISTRATION Employed fathers in Britain have a statutory right to time off to attend two antenatal appointments. Each father (or woman's partner) should (with the pregnant woman's consent) be formally registered with maternity services and an official invitation to participate issued. This will acknowledge the father as a parent, enable both to be properly informed and permit accurate information to be gathered from the father: his genetic history, characteristics and circumstances, health status, health behaviours (including any related to domestic violence perpetration), and so on. Risks relating to him can be flagged up and referrals (e.g. to smoking cessation) made and monitored. Working groups in each of the four countries in the UK should be established to consider mechanisms for dual registration in different settings and to identify potential pilot sites. RECOMMENDATON 3: POLICY Maternity services in the UK should be formulated as 'woman-focused and family-centred' meaning that, while the obstetrics focus remains on the pregnant woman, the father or woman's partner and other key supporters are actively encouraged to become an integral part of all aspects of maternal and newborn care. This formulation first appeared in the National Service Framework for Children, Young People and Maternity Services (DfES & DH, 2004) and is re-stated in the Forward Plan for Maternity and Neonatal Care in Scotland (Scottish Government, 2017) and by the Conservative Parliamentarians Group (Bruce & Farmer, 2017). Hospitals should collect information about the experiences of mothers and fathers/	Thank you for your comment. 1. The scoping group agreed that 'partner' is the preferred term to be used in the guideline. 2. In light of stakeholder comments, the guideline now includes an evidence review question on how to involve partners during antenatal care. 3.The committee will consider your comment during the development of the recommendations for this guideline.

					women's partners of family-centred care, as part of the NHS Friends and Family Test; and working groups in each of the four countries in the UK should be established to define family-centred care during pregnancy, at the birth and in neonatal care; and to explore strategies, objectives and targets for implementation.	

115	SH	Fatherhood Institute	General	FINAL THREE OF SIX RECOMMENDATIONS FROM THE forthcoming Fatherhood Institute review of the UK literature (Nuffield Foundation funded) - *Who's the Daddy? British fathers in the antenatal period and at the birth*	RECOMMENDATON 4: TRAINING AND CORE COMPETENCIES The term 'midwife' means 'with woman' and most practitioners in maternity and neonatal care services are not trained to engage effectively with men or to work in a 'partnership of care' with families, including understanding and engaging with gender issues and other family dynamics. Pre- and post- registration training curricula and CPD modules should be revised to cover the 'whys' and 'hows' of engaging with fathers and other her birth partners. When core competencies are time-tabled for revision, relevant new competencies should be drafted and included. Existing training modules (such as the NCSCT module on smoking in pregnancy) should, when revised, equip healthcare practitioners to engage with both parents, rather than only with the woman. RECOMMENDATON 5: INFORMATION FOR MOTHERS AND FATHERS Every maternity service should be required to provide information directly to the father/ woman's partner, rather than relying on the 'woman as educator'. The content of antenatal information/ education should include the neurobiology of active caretaking (in relation to both fathers and mothers), co-operative caregiving (the 'parenting team') and the impacts of father involvement and couple functioning on the infant's health and development. 'Father-proofing' guidelines to equip authors of new resources (and of resources that are being revised) to address both parents effectively should be developed and made available to commissioners, authors and editors, with the requirement that these be applied and utilized as part of the gender equality impact assessment. RECOMMENDATON 6: RESEARCH When guidelines and/ or recommendations for maternal and neonatal care are drawn up, for example by the National Institute for Health and Care Excellence (NICE), these should routinely include the evidence on the impacts of fathers' characteristics and behaviours on mother and infant; impacts of couple relationship functioning; and impacts of fatherhood on men. Any future 'birth' cohort study (or a component thereof) should collect data in pregnancy from both partners (cohabiting or living separately), with a phase of testing for recruitment approaches. If data collection in pregnancy proves impossible, the 'first sweep' interview (in infancy) for fathers/ partners should be expanded to ask about pregnancy and the birth. Where we have identified gaps in primary research and/ or in secondary analyses of data already collected, primary research or secondary analysis of existing	Thank you for your comment. 4.Training is outside of the remit of this guideline. 5.The guideline includes an evidence review question on what information do partners and families value as part of antenatal care and in light of stakeholder consultation we have now added an evidence review question on how to involve partners during antenatal care. 6. If gaps in the evidence are identified, the committee will be able to formulate recommendations for research.

					cohort data should be commissioned. Research and/ or analysis gaps include couple relationships; fathers' attitudes + beliefs+ preferences towards infant feeding and caring for infants; mothers' and fathers' preferences in relation to fathers' birth attendance; fathers' reports of support to them in pregnancy from mother, family, friends and peers.	

116	SH	Fatherhood Institute	NICE special question	Which interventions or forms of practice might result in cost saving recommendations if included in the guideline?	Couple-directed perinatal interventions such as FAMILY FOUNDATIONS http://famfound.net/about-us/ which has been adapted for the UK by the Fatherhood Institute and trialled in a number of locations. However, we think that the most cost-effective results will be achieved by reorienting routine antenatal engagement with parents to engage with BOTH, including inviting the father/woman's partner to at least one routine antenatal appointment and registering him on the woman's care plan – but with his own status. Midwives meet more fathers than do any other professionals. In the antenatal period, fathers are present and waiting to be engage with. More than 75% of first time fathers attend at least one routine antenatal appointment already, even with NO encouragement to do so, and more than 9 out of 10 attend the scans and the birth. HCPs need to be trained in engaging with fathers alongside mothers, and INSTRUCTED to do so appropriately (with the pregnant woman's consent, of course), with monitoring and evaluation in place.	Thank you for your comment. In light of stakeholder comments, the guideline now includes an evidence review question on how to involve partners during antenatal care.
117	SH	Fatherhood Institute	New question drafted by us, above	How and at which time points and in relation to which issues, will HCPs be directed to engage with the pregnant woman's partner?	Throughout – from the Booking In Appointment. Time should also be reserved during the course of routine antenatal appointments, to engage with each parent separately, as either or both may have important information to share independently. This is no truer of mothers than fathers. Very few fathers will attend all antenatal appointments so there are likely to be many opportunities to engage exclusively with the mother. Opportunities to engage exclusively with the father (with the mother's consent) would need to be consciously considered. Mental health, breastfeeding, smoking and substance use, diet and exercise, fathers' role during labour and birth and in the immediate postnatal period, baby shaking, infant development – all are issues which, if addressed with both parents, are likely to result in lower perinatal mortality and morbidity as well as better outcomes for infant, mother and father in the short and longer term.	Thank you for your comment. In light of stakeholder comments, the guideline now includes an evidence review question on how to involve partners during antenatal care.

118	SH	Fatherhood Institute	New question drafted by us, above	How will the information needs of, and information-giving by, the pregnant woman's partner and family be addressed within maternity services?	Existing NHS information for 'parents' needs to be reoriented, as it comes up for revision, to ensure it addresses the roles and concerns of both parents. Competencies and guidelines for HCPs need to equip them with skills, strategies and information to engage with fathers as well as mothers, and provide relevant information to them.	Thank you for your comment. In light of stakeholder comments, the guideline now includes an evidence review question on how to involve partners during antenatal care.
119	SH	Future of Downs	General	General	The current scope needs to be more explicit with respect to continuing care for pregnant people where antenatal screening in accordance with the UK NSC Fetal Anomaly Screening Programme (FASP) identifies a possible prenatal diagnosis. This is applicable for all screened conditions, however, due to the remit of Future of Downs this response will focus entirely on the approach for pregnant people where screening indicates a high likelihood of Down syndrome in the unborn foetus. Future of Downs (FoD) provides a National support network for pregnant people who receive positive prenatal diagnosis of Down Syndrome or who are given a high chance that their baby will have Down Syndrome but have refused further diagnostic testing. Disappointingly we regularly receive feedback from our members showing disparity in approach to screening and subsequent counselling/support nationally. The only consistency is a complete lack of consistency. Additionally, we are frequently alerted to concerning practices from individuals and institutions including coercion to consent to screening, lack of balance in counselling, frequent questioning and undermining of parental decision	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline. The specifics of counselling, information and procedure are all covered by the Fetal

					making. Upon receipt of a prenatal diagnosis of Down syndrome or indication of a high likelihood of Down syndrome in the unborn foetus some pregnant people are referred on to additional support pathways that are indicated by the diagnosis including fetal echocardiography, increased monitoring for IUGR. Yet other pregnant people receive no additional antenatal care than the standard pathway. A prenatal diagnosis or high likelihood of Down syndrome may predispose an individual to higher chance of complications and potential comorbidities associated with Down Syndrome may mean that birth plans may need to accommodate for the need for increased neonatal care. It is necessary for this guideline to address these possibilities and advise standard best practice to be observed by revelant healthcare providers and support services. In March 2017 Nuffield council on Bioethics report on Non-invasive prenatal testing recommended that 'NICE should produce clinical pathway guidance on continuation of a pregnancy after diagnosis of fetal anomaly'. (http://nuffieldbioethics.org/report/non-invasive-prenatal-testing-ethical-issues/conclusions-recommendations accessed 18 April 2018) In July 2016 Chitty et al published data from the RAPID study into use of NIPT in an NHS setting and informed the subsequent decision of UK NSC to recommend NIPT this study concluded that maternity services must have pathways for families using NIPT for information to prepare themselves for the birth of a baby with Down syndrome. (https://www.bmj.com/content/354/bmj.i3426 accessed 18 April 2018) Pregnant people with a prenatal diagnosis of Down syndrome or high likelihood of Down syndrome deserve a consistent high standard of care. This is not the case at present. An example of international guidance is the Practise Reource for Health Care providers Management of Pregnancies diagnosed with Down Syndrome January 2018 published by Perinatal service of Britsih Columbia Canada. http://www.perinatalservicesbc.ca/documents/guidelines-standards/maternal/downsyndromepracticeresource.pdf	Anomaly Screening Programme (FASP), which we will signpost in the guideline.

120	SH	[Group B Strep Support]	General	General	The box above this form asks which interventions or forms of practice might result in cost saving recommendations if included in the guideline. Research has shown that most early-onset group B Strep infection in babies is preventable when intravenous antibiotics are given in labour to women whose babies are at raised risk of developing the infection. By ensuring that appropriate information about group B Strep is provided to pregnant women, health professionals can ensure those women whose babies are at raised risk of EOGBS infection are offered prophylaxis, as described by the RCOG and NICE's CG149. This will improve the prevention of EOGBS infection, save tiny lives and result in cost-savings by reducing the costs of treating avoidable EOGBS infection both at the time of the infection, and for those children with ongoing health care needs.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
121	SH	[Group B Strep Support]	3	20-23	Whilst the UK National Screening Committee currently recommends against routine antenatal screening for all pregnant women, the RCOG's Greentop Guideline #36 (https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg36/) recommends not only that all pregnant women should be provided with an information leaflet about group B Strep, but also that in certain situations testing for GBS carriage should be offered, and describes the situation in which women should be offered intrapartum antimicrobial prophylaxis against EOGBS in their babies. How health professionals should care for pregnant women whose babies are at raised risk of developing EOGBS infection should be covered in this guideline.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.

122	SH	[Group B Strep Support]	3	24	There should be signposting to the RCOG's Greentop Guideline #36 on GBS (https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg36/).	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
123	SH	[Group B Strep Support]	5	9to22	A key area that should be covered by this guideline is the prevention of EOGBS infection. This should be an explicit key area, as are listeria and salmonella infection.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
124	SH	[Group B Strep Support]	7	6	Suggest the Neonatal infection (early onset) NICE guideline should be hyperlinked to https://www.nice.org.uk/guidance/cg149	Thank you for your comment. Neonatal care is not included in our scope but is included in the NICE Postnatal Care guideline scope and a reference to the Neonatal Infection (early onset) guideline is included there: https://www.nice.org.uk/guidance/gid-

						ng10070/documents/final-scope (p.19)
125	SH	[Group B Strep Support]	9	7	Bounty has undertaken 4 surveys of pregnant women/new mothers about what information they want about group B Strep as part of routine antenatal care (in 2010, 2013, 2015 and 2017). Consistently they have found that women want information about group B Strep (https://gbss.org.uk/press-releases/issued-on-11092017/ - further information available on request). In addition, the RCOG and GBSS have worked together to produce a joint patient leaflet on group B Strep to meet the information needs of expectant women about group B Strep https://www.rcog.org.uk/en/patients/patient-leaflets/group-b-streptococcus-gbs-infection-pregnancy-newborn-babies/. Including information on caring for and providing information to women whose babies are at raised risk of developing EOGBS infection, and signposting to the RCOG/GBSS patient leaflet in this guideline would help to ensure pregnant women's information needs re GBS are met.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
126	SH	[Group B Strep Support]	10	32	Section specifically on the prevention of EOGBS infection should be included here.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.

127	SH	Individual – Care Practitioner working with disabilities.	General	General	Do you plan a specific care pathway for women with a diagnosis of Down syndrome? In 2016 Down Syndrome had the highest rate of terminations under band E (706), significantly higher than any other abnormality. The NHS must be committed to providing Non-directive advice and support must be available to women and families. (Abortion statistics 2016)	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline.
128	SH	Midwifery Unit Network	9	7 (1.1)	It is positive to see the emphasis on 'what information women value'. We would suggest that if women are to make informed decisions about packages of care and place of birth, they also need reliable evidence-based information. We would suggest adding a question: What the quality of information available for women and families? This would need to be answered drawing on social and epidemiological research on the quality of information for women (quantitative, qualitative and mixed-methods) regarding decisions taken during pregnancy and antenatal care, especially with respect to place of birth. (Relevant studies include: Birthplace in England case studies, and Henshall et al systematic review.)	Thank you for your comment. In light of stakeholder comments, the guideline now has a question on effectiveness of the approach to information giving during antenatal care.

129	SH	Midwifery Unit Network	9	15 (2.4 & 2.5)	Content and delivery of antenatal care We are pleased to see included: What aspects of antenatal care delivery are valued by women? We would expect this to consider women's experiences of continuity of midwifery carer vs. non-continuity models, either alone or in combination with continuity of carer by other professional groups vs. non-continuity models.	Thank you for your comment and information. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. in the NICE guideline on patient experience in adult NHS services.
130	SH	Midwifery Unit Network	9	15	Content and delivery of antenatal care This aspect of the investigation should also include: What models of ANC are valued by women and are associated with positive psychosocial and clinical outcomes, including models of group-based ANC sessions and models designed to integrate developing confidence in motherhood alongside clinical check ups.	Thank you for your comment. The committee will consider this area during protocol development for the evidence review questions on content and delivery of antenatal care.

131	SH	Midwifery Unit Network	9	22(2.5)	· Is continuity of carer effective in antenatal care, and is it valued by women? It would be helpful to extend this and ask about: What aspects of antenatal care enable women to achieve POSITIVE experiences of care, including transition to a positive birth experience, and feeling positive about the transition to motherhood? Outcomes to include maternal wellbeing measures in both the short and long term, and not just 'satisfaction'. (See qualitative evidence summarised in the WHO ANC guidelines.) the experiences of women who start off the 'low-risk' care pathway and value social model of care they can sometimes access when on it (e.g. women planning for a home birth may have continuity of midwifery carer from a small dedicated home birth group/team) who subsequently need to have medical care for gestational diabetes, perceived growth restriction, etc. Are there studies comparing Continued access to continuity of carer midwives vs. loss of the continuity of midwifery care model? Anecdotal evidence suggests that this transition creates a serious gap in the delivery of 'personalisation' of care.	Thank you for your comment and information. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. in the NICE guideline on patient experience in adult NHS services.

132	SH	Midwifery Unit Network		general	What are the impacts of the NHS England's Saving babies' lives care bundle, which aims to improve awareness of fetal movement and reduce the rate of stillbirths? How many women have additional antenatal appointments due to concern about reduced fetal movements? How frequently do women return for antenatal appointments due to concern about reduced fetal movements? Do women who have continuity of midwifery carer report similar of different rates of reduced fetal movements? How do outcomes differ? How many women have labour induced because of reduced fetal movements? How many additional inductions (or caesarean births) are carried out to reduce stillbirths by 1? Does increased awareness of fetal movements/reduced fetal movements have any impact on short/long term levels of anxiety, postnatal wellbeing and maternal self efficacy? What proportion of women are moved from 'low risk' to higher risk as a result of 'improved awareness of fetal movement', in total and segmented by parity and by maternal age? Are alongside midwifery units available to women with reduced fetal movements? Details of the AFFIRM abstract are attached.	Thank you for your comment. The committee will consider your points during the development of the protocols for the evidence review questions on monitoring fetal growth and wellbeing.

133	SH	Midwifery Unit Network		general	What is the impact of the GAP/GROW intervention? This needs to be assessed in terms of both benefits and costs (clinical, social and economic). Particular areas to be addressed are the impact on antenatal care practices and care pathways, the impact for those perceived to have a large for dates baby, and impact of changing IOL practice and trends over time: Antenatal care practices and care pathways - How is the GAP/GROW intervention applied across all antenatal care? What is the evidence around assessing fetal growth, including the evidence re the routine ultrasound scan (USS) at 36 weeks? Look specifically at impact on: How many women moves from midwifery-led care to obstetrician-led care? What is the impact of this on the maternity services and numbers accessing home birth, FMU, AMU and obstetric unit intrapartum care? What is the impact for women of change of care pathway? Those perceived to have a large for dates baby(over 90th centile) - what is the impact on: induction of labour (IOL) rates, experiences for women (wellbeing, anxiety and maternal self-efficacy, short and longer term), choice of place of birth, and caesarean section rate? Induction of labour - What out the outcomes for babies whose births are induced? We need to know: about morbidities for women and babies associated with IoL as well as any changes in mortality rates, and have we got the data we need to monitor trends over time or even what is happening in any given year? (NB public money is being spent on the Maternity Services Dataset and the Maternity and Perinatal Audit, but both are very incomplete.) NB It is important to establish whether and to what extent GROW has been subject to RCT evaluation and the full range of effects found on primary and secondary outcomes, including unintended consequences. So far as we are aware, the only evidence was correlational. We not that there	Thank you for your comment. The committee will consider growth restriction during the development of the evidence review on fetal growth monitoring. Induction of labour for suspected macrosomia will be covered in the update of CG70. For further details please see: https://www.nice.org.uk/Guidance/CG70

					appears to be a correlation with a decline in stillbirth rate but there has also been an increase in early neonatal mortality. Could this be related? …./continued	

134	SH	Midwifery Unit Network			One of us was told that there was a stepped wedge trial in London, but that by the time this started there appeared to be very few units left which weren't using the intervention (there having been pressure to introduce it). To what extent did this initiative contribute to the new steep increase ('an epidemic') of inductions? (Increases in induction rates are frequently referred to as 'a result of women's choice', but a key question is 'What information are women given which informs their decision-making, and what was the evidence?	Thank you for your comment. As part of the information that will be given to women we will be referring to the induction of labour guideline CG70. For further details please see: https://www.nice.org.uk/Guidance/CG70
135	SH	Midwifery Unit Network		general	The guidance needs to be CG138 1.5.24 compliant: Use the following principles when discussing risks and benefits with a patient: personalise risks and benefits as far as possible use absolute risk rather than relative risk (for example, the risk of an event increases from 1 in 1000 to 2 in 1000, rather than the risk of the event doubles) use natural frequency (for example, 10 in 100) rather than a percentage (10%) be consistent in the use of data (for example, use the same denominator when comparing risk: 7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5) present a risk over a defined period of time (months or years) if appropriate (for example, if 100 people are treated for 1 year, 10 will experience a given side effect) include both positive and negative framing (for example, treatment will be successful for 97 out of 100 patients and unsuccessful for 3 out of 100 patients) be aware that different people interpret terms such as rare, unusual and common in different ways, and use numerical data if available think about using a mixture of numerical and pictorial formats (for example, numerical rates and pictograms).[1][QS]	Thank you for your comment. All NICE guidance should be read alongside CG138 Patient experience in adult NHS service. Any recommendations made by this guideline will be in addition to CG138 (and specific to antenatal care) but will not supersede the recommendations made by CG138.

136	SH	Midwifery Unit Network		general	The guidance needs to be CG138 1.5.14 compliant: Explore the patient's preferences about the level and type of information they want. Based on this, give the patient (and their family members and/or carers if appropriate) clear, consistent, evidence-based, tailored information throughout all stages of their care. This should include, but not be limited to, information on: their condition and any treatment options where they will be seen who will undertake their care expected waiting times for consultations, investigations and treatments.[1]	Thank you for your comment. All NICE guidance should be read alongside CG138 Patient experience in adult NHS service. Any recommendations made by this guideline will be in addition to CG138 (and specific to antenatal care) but will not supersede the recommendations made by CG138.
137	SH	Midwifery Unit Network		General	The guideline should pay close attention to the 'Right Care' (Avoiding too much medicine) agenda, and to the criteria for effective screening tests, since much of antenatal care is about screening: The Wilson criteria for screening emphasise the important features of any screening program, as follows: • the condition should be an important health problem • the natural history of the condition should be understood • there should be a recognisable latent or early symptomatic stage • there should be a test that is easy to perform and interpret, acceptable, accurate, reliable, sensitive and specific • there should be an accepted treatment recognised for the disease • treatment should be more effective if started early • there should be a policy on who should be treated • diagnosis and treatment should be cost-effective • case-finding should be a continuous process	Thank you for your comments. The UK National Screening Committee (UK NSC) recommends screening for pregnant women for a range of maternal and fetal disorders and this guideline will signpost the relevant advice. We have also revised 'disorders' with 'conditions' in the scope in light of stakeholder consultation.

138	SH	Midwifery Unit Network	10	1	Monitoring fetal growth and wellbeing (and linked to Determining gestational age P9, line 30) A more general question is required on the frequency of use of ultrasound during pregnancy. Has the current use of ultrasound to be investigated? What is the evidence for (cost) benefit for its use once, twice, or more often in pregnancy in terms of reduction in adverse outcomes/increase in unintended harms?	Thank you for your comment. The points you make about frequency of fetal growth monitoring will be considered by the committee during the development of the protocols for the evidence review questions on monitoring of fetal growth and well-being.
139	SH	[NHS England]	1	6	The draft scope suggests that only a third of women accessed a midwife as a point of contact for antenatal care? Will this be explored further as part of the guideline? This could further explain why women book late for antenatal care. This could be for several reasons including ethnicity, language, social factors, or choice. This has a potential impact on	Thank you for your comment. In light of stakeholder comments, we have now included an evidence review question on the effectiveness of different methods to access antenatal care.
140	SH	[NHS England]	3	3	Agree preterm birth clinics and “rainbow clinics” have a reported impact but not clear how this fits into the scope of this guideline. Are you proposing that specialised clinics are set up for low risk antenatal care?	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline.

141	SH	[NHS England]	3	20	Dr Liz Thomas & Dr Nikita Kanani: It would be helpful if a statement or link is explicitly included which refers to screening for group B streptococcus	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
142	SH	[NHS England]	3	25	NHSE welcomes reference to vaccinations	Thank you for your comments.
143	SH	[NHS England]	3	25	NHSE welcomes any signposting and support in the delivery of Saving Babies Lives	Thank you for your comments.
144	SH	[NHS England]	6	7	It is stated that travelling abroad during pregnancy will not be updated, should any reference be made to Zika?	Thank you for your comment. Advice on Zika is covered by NHS guidance (as would advice regarding any emerging infection) and is outside of the remit of a clinical guideline.
145	SH	[NHS England]	9	11	Joy Kirby: Women should be provided with information that is evidence based (not Provider based). The information should be in simple language (the public information on the NICE website is a good example) and should be published in the language of the most common ethnic minorities.	Thank you for your comment. The language used in the recommendations will be carefully considered by the committee. Please also note that the draft guideline will published for consultation among stakeholders, which will

						provide an additional safeguard in relation to the final wording of the recommendations.
146	SH	[NHS England]	9	14	Joy Kirby: The effectiveness and values of antenatal programmes should include what women find helpful. It would be helpful to understand what a good programme looks like.	Thank you for your comment. The committee will consider your points during the development of the protocols for the evidence review questions on what information women and their families value as part of antenatal care.
147	SH	[NHS England]	9	21	NHSE welcome any evaluation by women relating to their care	Thank you for your comments.
148	SH	[NHS England]	9	22	NHSE welcome any evaluation of continuity of carer –	Thank you for your comment and information. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. of the NICE guideline on patient experience in adult NHS services.
149	SH	[NHS England]	9	22	Joy Kirby: It would be helpful to understand what it is that women value in terms of continuity of carer in the antenatal period.	Thank you for your comment and information. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer

						to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. of the NICE guideline on patient experience in adult NHS services.
150	SH	[NHS England]	General		Is there evidence either way on whether self-referral straight to a midwife (as opposed to having to see a GP first) is acceptable, or recommended?	Thank you for your comment. As part of the area on content and delivery of antenatal care we will be looking at effectiveness of the different methods to access antenatal care. The committee will consider your comment during the development of the protocol.
151	SH	NICE	general		The areas covered in QS22 on antenatal care generally support the focus of the update to CG62. We have also carried out some preliminary engagement work with stakeholders for a quality standard on maternal health which supports the proposed focus on providing information about alcohol use during pregnancy, the risk of mental health problems for pregnant women and the promotion of MMR, flu and pertussis immunization during pregnancy. Full development of this quality standard will start later in 2018.	Thank you for this informaiton.

152	SH	NICE	9	16	QS22 on antenatal care has 2 statements (8&9) on risk assessment for venous thromboembolism based largely on the RCOG Thrombosis and embolism during pregnancy Green-top guideline 37a. It would be helpful if the update to CG62 could include information on assessment of this risk during antenatal appointments.	Thank you for your comment. The scoping group has decided that risk assessment for venous thromboembolism should be covered in this guideline and three new questions have now been added to the scope to cover assessment of this risk during antenatal care.
153	SH	NICE	12	9	· Three other quality standards also use CG62 as evidence and may therefore also need updating as follows: QS35 Hypertension in pregnancy QS98 Maternal and child nutrition QS105 Intrapartum care Please note that the following indicators on the NICE menu may also be need updating when the guideline is updated: Proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days Proportion of women who receive antenatal assessments by 13 weeks of pregnancy Proportion of pregnant women who were smokers during pregnancy Proportion of pregnant women who were asked about their mental health at their first booking appointment	Thank you for your comment. The scope has been revised and now includes these 3 quality standards. We have also noted that several indicators on the NICE menu may need updating.
154	SH	Nuffield Council on Bioethics	1	10	This line suggests that the new guideline will cover all aspects of antenatal care. The guideline is referred to as the guideline on 'antenatal care' in other places as well (e.g. page 5, line 26). However, in several other places, the consultation states that the new guideline will focus on antenatal care in uncomplicated pregnancies only, and will not cover the care of women with complicated or multiple pregnancies (e.g. page 5, line 24). It would be helpful if the scope of the guideline was clarified at the beginning and a descriptive title used throughout.	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside

						specialised care which is not covered in this guideline.

155	SH	Nuffield Council on Bioethics	General	General	We strongly urge NICE to expand this guideline to include the care of women who continue their pregnancy following a diagnosis of fetal anomaly, or to produce a separate guideline on this area of care. Women with high-chance combined test screening results will be able to access non-invasive prenatal testing (NIPT) in the NHS later in 2018. The introduction of NIPT as a second stage test is likely to lead in numerical terms to both more terminations of pregnancy following a diagnosis of Down's, Edwards' or Patau's syndromes, and more pregnancies being continued than is currently the case (Nuffield Council on Bioethics (2017) Non-invasive prenatal testing: ethical issues, paragraph 2.43). Both NICE and the Royal College of Obstetricians and Gynaecologists (RCOG) have produced professional guidance on termination of pregnancy. However, there are no NICE guidelines on the care of women who continue their pregnancy following a diagnosis, and the RCOG guidelines on this are sparse and hidden in its guidance on termination of pregnancy. A need for better professional guidance on continuing a pregnancy following a diagnosis of fetal anomaly was identified in a recent inquiry on NIPT by the Nuffield Council on Bioethics. The Council recommends that such guidance should include the care of women who receive a high chance or positive NIPT result, as well as those who undergo invasive diagnostic testing. It should be emphasised that following a diagnosis or a high chance NIPT result, women should have access to advice from a wide range of experts, including those with first-hand knowledge of children and adults with genetic conditions and impairments and their families, and they should have the option of receiving specialist care and support throughout their pregnancy or remaining on the standard antenatal care pathway. For more information, see Nuffield Council on Bioethics (2017) Non-invasive prenatal testing: ethical issues, available at: www.nuffieldbioethics.org/NIPT.	Thank you for your comment. The scope has been revised to clarify that this guideline is applicable to all pregnant women including those with maternal and/or fetal conditions as these women continue to need normal antenatal care alongside specialised care which is not covered in this guideline. The specific needs of these women is outside of the remit of this guideline.

156	SH	Nuffield Council on Bioethics	5	6	We recommend that antenatal screening is included in the key areas to be covered in the update. Although it is stated that the guideline will signpost to the NHS antenatal screening programmes (page 3, line 9), it would be helpful if NICE also considered recent changes to the screening programme in this update, given that the forthcoming introduction of NIPT will lead to a significant change in the information to be provided to pregnant women about screening, and the choices that they might be asked to make. Antenatal screening is included in the current NICE guideline on antenatal care for uncomplicated pregnancies and the removal of this area from the updated guideline is not explained.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
157	SH	Public Health England	4	17	The equality impact assessment focusses on disability, but evidence shows that the age of mother and her socio-economic status are also significant areas of inequality in terms of healthy outcomes and propensity to access support and we suggest broadening it to take into account these additional characteristics.	Thank you for your comment. We agree that age and economic status are significant factors to consider during antenatal care. The reason why they are not covered in the equality impact assessment is because they are explored in the pregnancy and complex social factors NICE guideline. For further details please see CG110 https://www.nice.org.uk/Guidance/CG110
158	SH	Public Health England	5	9	The guideline should include information that a women is entitled to free National Health Service (NHS) dental treatment if she is pregnant when she starts treatment and for 12 months after the baby is born to ensure that relevant information is given in the guideline, and to women by teams using the guideline.	Thank you for your comment. The committee will consider this during the protocol development for the evidence review question on information and support if they wish to advise that there should be a discussion about what treatment is available.

159	SH	Public Health England	5	13/14	If weight management will be included, the guideline should include proportionate evidence that consumption of free sugars is a risk factor for both obesity and dental caries Ref: Public Health England (October 2015) The relationship between dental caries and obesity in children: an evidence summary. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/466334/Caries_obesity_Evidence_SummaryOCT2015FINAL.pdf For reference, PHE guidance in relation to nutrition during pregnancy is detailed below: PHE promotes the importance of a healthy diet and keeping active during pregnancy. Although energy needs increase slightly (by about 200 kilocalories per day) in the last three months of pregnancy, expectant mothers are advised that there is no need to 'eat for two' and instead to eat healthily, ensuring they are consuming a variety of different foods every day in order to get the right balance of nutrients for both themselves and their baby. Dieting during pregnancy is not recommended. Detailed advice covering pregnancy and caring for newborn infants, babies and toddlers, is provided in the NHS Choices Pregnancy and Baby Guide. This includes advice on healthy eating (based on the Eatwell Guide), foods to avoid, vitamins and minerals (including supplements), breastfeeding, and the introduction of complementary foods. NHS Choices advice A healthy diet is an important part of a healthy lifestyle at any time, but is especially vital if you're pregnant or planning a pregnancy. Eating healthily during pregnancy will help your baby to develop and grow. You don't need to go on a special diet, but it's important to eat a variety of different foods every day to get the right balance of nutrients that you and your baby need. It's best to get vitamins and minerals from the foods you eat, but when you're pregnant you need to take a folic acid supplement as well, to make sure you get everything you need.	Thank you for your comment. This guideline will not undertake new evidence review on these areas, but will refer to relevant existing NICE guidance.

					You will probably find that you are hungrier than usual, but you don't need to "eat for two" – even if you are expecting twins or triplets. https://www.nhs.uk/conditions/pregnancy-and-baby/healthy-pregnancy-diet/	

160	SH	Public Health England	5	14	Work and lifestyle - We suggest that smoking is listed specifically, as tobacco addiction is not a 'lifestyle choice'. https://www.drugabuse.gov/publications/tobacco-nicotine-e-cigarettes/nicotine-addictive	Thank you for your comment. The scoping group has decided that smoking is appropriate under the key area of 'lifestyle'.
161	SH	Public Health England	6	17	Preconception care guidance to be included here https://cks.nice.org.uk/pre-conception-advice-and-management	Thank you for your comment. Preconception care will not be included as part of this guideline.
162	SH	Public Health England	6	16	Include link to NICE Clinical Guideline CG19 Dental checks: intervals between oral health reviews https://www.nice.org.uk/guidance/cg19	Thank you for your comment. This NICE guideline is outside of the remit of this guideline.
163	SH	Public Health England	6	16	Include link to Oral health promotion: general dental practice (NG30) https://www.nice.org.uk/guidance/cg19	Thank you for your comment. This NICE guideline is outside of the remit of this guideline.
164	SH	Public Health England	7	28	Include recent guidance on "Stop smoking interventions and services NICE guideline [NG92] https://www.nice.org.uk/guidance/ng92. This may supersede the brief intervention and referral guidance referenced in lines 27-28	Thank you for your comment. We will add https://www.nice.org.uk/guidance/ng92 to the guidance list. NG92 has replaced PH1 so this will be removed from the related guidance list. PH26 and PH48 are still current guidelines, although there are plans in development to merge the tobacco guidance into a single tobacco guideline which is due to publish in January 2020.
165	SH	Public Health England	9	5	PHE recommend including a question related to postnatal contraception e.g. What advice should be given to women regarding postnatal contraception? This is in line with the new Faculty of Sexual and Reproductive Health guideline 'Contraception	Thank you for your comment, however this is

					After Pregnancy': https://www.fsrh.org/news/new-fsrh-guideline--contraception-after-pregnancy/	outside of the remit for this guideline.
166	SH	Public Health England	9	5 7 9 11 13 15	This focused on the support and information that women and partners "value". We would also recommend focusing on the interventions and support that will give the most value / have a significant impact on health outcomes for women, E.g. Very brief advice on smoking and referral to behavioural support.	Thank you for your comment. The committee will consider your comment during the development of the protocols for the evidence review questions on the effectiveness of different means of information and support provision.
167	SH	Public Health England	10	16	We recommend changing 'exercise' to 'physical activity', since being active can be incorporated into daily life without specific 'exercise'.	Thank you for your comment. Physical activity in pregnancy will be included in the NICE guideline on weight management before, during and after pregnancy, when the guideline is updated and therefore will not be covered by this guideline.
168	SH	Public Health England	10	18-22	We suggest an evidence review on the impact of financial incentives within smoking cessation, as this is an area not covered by the 2010 PH26 NICE Guidance, and it is an area where there has been some new published research which could be considered as part of routine antenatal care.	Thank you for your comment. The new published evidence to which you refer will be taken into account when an update of PH26 is considered. The evidence on smoking cessation and pregnancy will not be reviewed as part of this guideline.

169	SH	Public Health England	General	General	Some of the main outcomes of the guideline are to reduce child mortality and morbidity, and to increase birth weight. Given this, more prominence should be given to smoking cessation and tobacco control within the scope of the guidance. Smoking is the biggest preventable risk factor for a number of poor outcomes in pregnancy, and babies born to smokers are, on average, 8% lighter than those born to never smokers. Ref: Healthy Lives, Healthy People: A Tobacco Control Plan for England. HM Government 2011 https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england Tobacco Advisory Group of the Royal College of Physicians. Passive smoking and children 2010(ISBN 978-1-86016-376-0).	Thank you for your comment. Smoking cessation will be based on the NICE public health guidelines PH26 and PH1. Smoking cessation will be recommended by signposting to other guidelines but the evidence will not be reviewed for this guideline.
170	SH	Royal College of Midwives	5	general	Antenatal classes are a very important aspect of antenatal care (with rising number of parents having to pay to attend courses even within the NHS with hypnobirthing), it would be useful to have guidance on the most appropriate content of antenatal education.	Thank you for your comment. The point you make about the content of antenatal classes will be considered by the committee during the development of the protocols on the evidence review questions on information and support for women and their families as well as the questions on the content and delivery of antenatal care.
171	SH	Royal College of Midwives	6 & 11	general	Management of common problems during pregnancy will exclude items from 3 to 15. Items 3-11 are common problems during pregnancy and are not not covered by any other NICE guidance	Thank you for your comment. We acknowledge that the list of 'common problems' is not exhaustive and was drawn up through a process of prioritisation by the scoping group focusing on those of potential major importance

						or those in which there is significant evidence.
172	SH	Royal College of Midwives	General	General	The RCM does not currently support routine screening for early-onset GBS (EOGBS). However, it is an issue of concern to women and guidance would be helpful. 20-30% of normal healthy women carry the bacteria and EOGBS infection is a leading cause of severe infection in babies, and a significant cause of neonatal mortality and morbidity. It is also an increasing problem - according to the latest BPSU study, the rate of EOGBS infection increased in the UK & Republic of Ireland by 19% (and the number of cases by 37%) between 2000/1 and 2014/5 (Group B Streptococcal disease in infants. Heath P. BPSU Annual Report 2015-2016. (2016). London: British Paediatric Surveillance Unit, pp.10-12. http://www.rcpch.ac.uk/system/files/protected/page/BPSU_AR1516_Web_0.pdf). In September 2017, the Royal College of Obstetricians & Gynaecologists published a major update to their Greentop guideline on group B Strep, recommending that all pregnant women should be provided with an information leaflet about group B Strep (Hughes RG, Brocklehurst P, Steer PJ, Heath P, Stenson BM on behalf of the Royal College of Obstetricians and Gynaecologists. Prevention of early-onset neonatal group B streptococcal disease. Green-top Guideline No. 36. BJOG 2017;124:e280–e305. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg36/). This guideline is not referenced in the scope. The NICE Neonatal Infection (early onset) guideline https://www.nice.org.uk/guidance/cg149 is referenced in the scope and "… covers preventing infection within 72 hours of birth in healthy babies, treating pregnant women whose baby is at risk, and caring for babies who have a suspected or confirmed infection."	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.

173	SH	Royal College of Nursing	3	23	Although the UK NSC have excluded Group B streptococcus from the screening programme will this be mentioned, or information sources signposted in the guideline? This is a significant concern for some parents.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
174	SH	Royal College of Nursing	6	42064	If these topics are to be excluded from the updated guidelines there needs to be clear signposting to where this information can be found for both healthcare professionals and women.	Thank you for your comment. Where appropriate there will be clear signposting to relevant NICE guidance.
175	SH	Royal College of Nursing	9	14 1.6	Antenatal classes and groups: may need to consider that not many women attend and some trusts no longer provide these. Many women seem to get most of their information from online sources.	Thank you for your comment. The committee will consider your comment during the development of the protocol for information and support.

176	SH	Royal College of Nursing	11	20, 21	Given the prevalence of new mental health problems in pregnancy, is it sufficient to refer to another guideline without also including some information and guidance?	Thank you for your comment, as there is an existing guideline on antenatal and postnatal mental health (CG192), we will cross-refer to this relevant guideline. For further information, please see: https://www.nice.org.uk/guidance/cg192
177	SH	Royal College of Nursing	General	General	How will diversity and health needs be addressed in the new guideline?	Thank you for your comment. An equality impact assessment has been carried out during scoping. The guideline will look at inequalities relating to disability. In terms of health needs, the guideline is applicable to all women including those with maternal conditions as they continue to need normal antenatal care alongside specialised care. Note that specialised care is not covered in this guideline.
178	SH	Royal College of Nursing	General	General	While this guideline is for uncomplicated pregnancies, there is no mention of termination of pregnancy. Given that some initially uncomplicated pregnancies may end in termination, should this be mentioned?	Thank you for your comment. Termination of pregnancy is outside the remit of this guideline. However please note that a NICE guideline on Termination of Pregnancy is currently in development. Please refer to

						https://www.nice.org.uk/guidance/indevelopment/gid-ng10058
179	SH	Royal College of Nursing	General	General	There is almost no mention of the woman's partner in the document. How will this deficit be addressed in the guideline?	Thank you for your comment. The guideline is proposing to look at information that is valued by women and their partners and families, and in light of stakeholder comments we are now also including an evidence review question on how to involve partners during antenatal care.
180	SH	Royal College of Nursing	General	General	How will the impact of the changes to the guideline be assessed?	Thank you for your comment. For every recommendation, the committee will consider their likely impact on practice. NICE will also conduct cost-impact analysis to establish the resource impact of recommendations.
181	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2	15-17	There will be no interventions which will prevent any of these complications, suggest "Reducing the risk of…"	Thank you for your comment. This has been revised accordingly.
182	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2	17	Unsure about the inclusion of 'prevention of rubella during pregnancy'. Immunisation against pertussis and influenza is recommended during pregnancy. Rubella is a live vaccine and should not be administered during pregnancy; the NSC antenatal screening programme for rubella discontinued in April 2016. Unless the updated guideline intends to refer to MMR immunisation outwith pregnancy then I would suggest that this is removed.	Thank you for your comment. We have revised this section accordingly.

183	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2	22	Management of co-existing conditions is a huge umbrella term. How will it be decided which conditions will be included?	Thank you for your comment. We acknowledge that the list of 'common problems' is not exhaustive and was drawn up through a process of prioritisation by the scoping group focusing on those of potential major importance or those in which there is significant evidence.
184	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2		It is worth noting that the RCOG are currently developing guidance on monitoring growth and wellbeing – (currently at scoping stage) and it would perhaps be worth liaising over this common area.	Thank you for your comment. It is useful to know and we will discuss with the committee.
185	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2		It is worth noting that the RCOG are currently developing guidance on reduced movements (first draft stage) and it would perhaps be worth liaising over this common area.	Thank you for your comment. It is useful to know and we will discuss with the committee.
186	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2		I note the planned removal of advice for constipation, varicose veins and backache. I am not aware that these are covered elsewhere, but would agree that there are unlikely to be significant new developments.	Thank you for your comment. We acknowledge that the list of 'common problems' is not exhaustive and was drawn up through a process of prioritisation by the scoping group focusing on those of potential major importance or those in which there is significant evidence.

187	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2		Discussion about reducing the risk of chickenpox and parvovirus infections should be considered.	Thank you for your comment. No further evidence reviews will be undertaken to address this key area and the guideline will refer to existing relevant NHS guidance.
188	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2		Discussion about screening programmes should be considered.	Thank you for your comments. The UK National Screening Committee (UK NSC) recommends screening for pregnant women for a range of maternal and fetal disorders and this guideline will signpost the relevant advice.
189	SH	Royal College of Obstetricians and Gynaecologists	Section 3.2		Discussion about NIPT and who should be offered this should be considered.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
190	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	10	Point 1.3 – the guideline developers should ensure that the provision of information regarding Group B Streptococcus is included in this section.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this

						information in this guideline.
191	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	16	Point 2.1 – the guideline developers should ensure that risk assessment for venous thromboembolic disease is included in this section.	Thank you for your comment. The scoping group has decided that risk assessment for venous thromboembolism should be covered in this guideline and three new questions have now been added to the scope to cover assessment of this risk during antenatal care.
192	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	26 and 28	These recommendations seem out of place here.	Thank you for your comment. The proposed review question was regarding when to identify breech antenatally and what effective interventions reduce the risk of breech presentation at birth (e.g. external cephalic version). We consider that they should be included as part of the content and delivery of antenatal care section.
193	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	28	Point 2.7 – the guideline developers should be aware that the RCOG updated their guidance on breech and external cephalic version in March 2017.	Thank you for your comment. It is useful to know, however please note that this guideline can only refer to other related NICE and NHS guidance.

194	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4; page 9	31	This is covered by BMUS and therefore unsure it is necessary here.	Thank you for your comment. It is useful to know, however please note that this guideline can only refer to other related NICE and NHS guidance.
195	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	1	Question 4 - the guideline developers should be aware of the NHS England Saving Babies Lives Care bundle which includes SGA.	Thank you for your comment. The committee will consider this during protocol development for the relevant areas.
196	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	43282	Point 4 - the guideline developers should be aware that the RCOG is currently updating its guidance on the detection and management of the small for gestational age fetus.	Thank you for your comment. It is useful to know, however please note that this guideline can only refer to other related NICE and NHS guidance.

197	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	4.6	Point 10.1 - the guideline developers should be aware that the RCOG produced guidance on the management of nausea and vomiting in pregnancy in June 2016.	Thank you for your comment. We can only refer to national policy or NICE guidance and therefore cannot refer to RCOG green top guidance. The committee will look at interventions for effective treatment of nausea and vomiting in pregnancy in question 10.1, though we cannot pre-empt recommendations made by the committee on clinical or cost effectiveness.
198	SH	Royal College of Obstetricians and Gynaecologists	Section 3.4	17	Question 11 – the guideline developers should be aware that the RCOG is currently developing obesity guidance.	Thank you for your comment. It is useful to know, however please note that this guideline will only refer to other related NICE and NHS guidance. In addition, we will be cross-referring to CG189. For further guidance please see: https://www.nice.org.uk/guidance/CG189
199	SH	Royal College of Paediatrics and Child Health	Page 12	Line 1, outcomes for baby	It is important to get away from 'birth weight' as an outcome: it is meaningless by itself as it conflates smallness for gestational age with gestational age. GA is important in its own right (not just term versus preterm), and SGA is important as, amongst other things, a risk factor for stillbirth, a measure of the impact of deprivation, and a marker for postnatal risk throughout infancy.	Thank you for your comment. We have changed the birthweight to birthweight centiles.

200	SH	Royal College of Paediatrics and Child Health	General	General	In the 2008 guidance it is stated at 1.7.1.8: "Participation in regional congenital anomaly registers and/or UK National Screening Committee-approved audit systems is strongly recommended to facilitate the audit of detection rates. [2008]" The National Congenital Anomaly and Rare Disease Registration Service has now been established by Public Health England, based on and extended from the former regional congenital anomaly registers. NCARDRS, working with the NSC, is becoming the system by which FASP and other antenatal and postnatal screening programmes are evaluated. The wording of this section therefore needs to be updated.	Thank you for your comment. The 2008 NICE antenatal guidance will be stood down once this guideline is published. Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
201	SH	Royal College of Paediatrics and Child Health	Page 5 & Page 9	Line 9 Line 6	"Information and support for women and their families". It is easy to forget that per 1000 pregnancies, stillbirths outnumber cot deaths by around 10 to 1, yet this is not reflected in the emphasis given to women in antenatal information. It is possible that information about reducing the risk of SB would have more impact if awareness of this fact was more widespread.	Thank you for your comment. Stillbirth is one of the outcomes of interest in the scope and will be considered by the committee when developing protocols for the guideline.
202	SH	Royal College of Paediatrics and Child Health	General	General	We could find no mention of folic acid supplementation. As this needs to be started at first (booking) appointment if the woman is not already taking it, there may be scope either for reviewing it or including it in this revision. The 2008 guidance states at 1.3.2.1: "Pregnant women (and those intending to become pregnant) should be informed that dietary supplementation with folic acid, before conception and throughout the first 12 weeks, reduces the risk of having a baby with a neural tube defect (for example, anencephaly or spina bifida). The recommended dose is 400 micrograms per day." This is fine for those with a planned pregnancy but for early bookers who did not plan, the risk of neural tube defects can still be reduced by starting folic acid at booking.	Thank you for your comment. We will not be reviewing the evidence but we will be signposting the recommendations from PH11. For further guidance, please see: https://www.nice.org.uk/Guidance/PH11.

203	SH	Royal College of Paediatrics and Child Health			The British Association of Perinatal Medicine has reviewed the draft scope of this guideline We endorse the provision of information to prospective parents, and recommend that such information for all parents includes a brief outline of the organisation of Neonatal Care in the UK (including networks), highlighting the fact that some babies (and mothers) may need to be moved from their booking hospitals (or diverted from home birth), either before or after birth, to receive the most appropriate care	Thank you for your comment. The suggestion you make will be considered by the committee during the development of the review protocols for the proposed questions on information and support for women and their families.
204	SH	Royal College of Paediatrics and Child Health			General statement regarding remit of guideline as adults >16 years. Suggest there needs to be some clarification around Children and Young people, particularly those with chronic health needs and / or learning difficulties as to whether they are included as adults from 16 and no longer accessing paediatric services, or if there is a different or flexible age cut off.	Thank you for your comment. The reason why young age is not explicit is because it is explored in the pregnancy and complex social factors NICE guideline. For further details please see CG110 https://www.nice.org.uk/Guidance/CG110
205	SH	Royal College of Pathologists and British Society for Haematology	10	9	Better management of maternal anaemia may result in fewer transfusions – important area to be included	Thank you for your comment. We have now added an evidence review question on when to test for anaemia during pregnancy.
206	SH	Royal College of Pathologists and British Society for	11	1 to 3	Further clarification required. There may be 2 issues –one the use of fetal DNA for Rh determination and the second is less clear- 'regimes for identifying blood group'. Does this relate to the current frequency of testing?	Thank you for your comment. The scope has now been revised and no longer makes specific reference to 'blood group, rhesus D status and red blood cell antibodies'. Instead, the review

		Haematology				question is about the effectiveness of screening for asymptomatic bacteriuria during pregnancy. However we have also added a note acknowledging that the NSC are currently undertaking an evaluation for screening related to this key area. We have explained that we will liaise with the NSC to determine whether an evidence review will be required to complement their evaluation.
207	SH	Society and College of Radiographers	6	15	Placenta praevia excluded. Will links be made to e.g. RCOG 'Greentop Guidelines'?	Thank you for your comment. The diagnosis of placenta praevia by definition makes the pregnancy no longer "uncomplicated" and the care of all significant complications are outside of the remit of this guideline.
208	SH	Society and College of Radiographers	General		Ultrasound examinations must be undertaken by staff who are properly trained and assessed as competent for the work that they do. The Society and College of Radiographers' recommendations are for a Consortium for the Accreditation of Sonographic Education (CASE) or RCOG accredited award, or equivalent if from overseas. FASP also have specific qualificatory requirements for professionals undertaking the two National Screening Programme scans that are offered during pregnancy. There is no statutory registration currently available as a 'sonographer' and there is no other supporting legislation relating to qualifications as there is for ionising radiation.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.

209	SH	Tavistock Relationships	5	General	Given the reduction in the quality of the couple relationship which becoming a parent generally entails – even in the most optimal circumstances – (as evidenced internationally, e.g. Doss, 2009), we believe that 'information and support regarding the relationship between a pregnant woman and her partner' should be included as a new and separate item on the list of key areas (i.e. 3.2) or, failing that, as a sub-heading in section 3.4.1. Becoming a parent has a significant impact on a couple relationship, and the inclusion of this item on the list of key areas would go some way to helping professionals and services acknowledge that this is an important aspect of antenatal care, which has the potential to improve outcomes for mothers, their partners and their children through helping couple to better deal with and negotiate the stresses and strains that they will undoubtedly face as the parents of a baby.	Thank you for your comment. We agree with you that partner involvement is important in the context of antenatal care. Our proposed review questions will look at the information that the partner value and the approaches to involve them in antenatal care.
210	SH	Tavistock Relationships	11	4	We believe that a new sub-heading – 'Interventions to support the couple relationship between a pregnant woman and her partner' - should be added to the section called 'Interventions for common problems during pregnancy'. Becoming a parent has a significant impact on a couple relationship, and the inclusion of this item would provide professionals and services with information about interventions which have the potential to improve outcomes for mothers, their partners and their children through helping couple to better deal with and negotiate the stresses and strains that they will undoubtedly face as the parents of a baby, as well as reduce the incidence and severity of inter-parental conflict between parents. Evidence shows that inter-parental conflict which is frequent, intense and poorly-resolved puts children's mental health and life chances at risk (Harold et al., 2016 – review published by the Early Intervention Foundation). The current list under the 'Interventions for common problems during pregnancy' only includes physical health difficulties. This is not satisfactory or adequate, given that relationship and emotional difficulties are also extremely common during uncomplicated pregnancies.	Thank you for your comment. We acknowledge that the list of 'common problems' is not exhaustive and was drawn up through a process of prioritisation by the scoping group. focusing on those of potential major importance or those in which there is significant evidence. However, you make an important point about the role of partners and the scope has been revised to include a question about approaches for involving partners during antenatal care.

211	SH	The Down's Syndrome Association	3	11	We would wish to see all guidance provided to professionals supporting women (and all public-facing information for women) convey that screening for Down's syndrome is offered to women, but not specifically recommended and that all decisions relating to whether a woman chooses any test (or none) is equally valid. Decisions relating to actions taken following screening and diagnostic test results should always be respected and women supported.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
212	SH	The Down's Syndrome Association	3	General	That NICE guidance GC62 "Antenatal Care for Uncomplicated Pregnancies, Screening for Fetal Anomalies" be updated to include the proposed offer of NIPT (as a contingency test to women in certain circumstances) and that it be noted there will be a significant difference in offer between the various nations of the UK (from April 2018).	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
213	SH	The Down's Syndrome Association	3	General	Information provided to women should include up to date, balanced and accurate information about the conditions beings screened for and should use neutral language. Information should include recent relevant lived experience of those individuals who have Down's syndrome and parents who have a child with the condition.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.

214	SH	The Down's Syndrome Association	3	General	Women should be able to gain rapid access to appropriately trained staff, who can support them to make informed decisions about what, if any, antenatal test they may choose to access. Appropriate, non-directive counselling must be given to process information relating to the results of any test and support a woman to reach a decision that is right for her. Recognition be given to time pressures within which midwives operate and an understanding that, to ensure informed decision making is possible, midwives (and antenatal screening midwives especially) need protected time to talk to women and answer questions	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
215	SH	The Down's Syndrome Association	3	General	Women need to appreciate that pregnancy scans may identify information that could lead to an indication of a fetal anomaly and understand the implications of being given this information and the decisions this information could prompt them to consider.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
216	SH	The Down's Syndrome Association	3	General	Health professionals supporting women should be aware of the support available from Third Sector organisations like The Down's Syndrome Association and SOFT-UK who can provide information and support at all stages of their pregnancy and post natally.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
217	SH	The Down's Syndrome Association	3	General	There is an absence of a national pathway for women continuing with a pregnancy with a diagnosis of Down’s syndrome- we would wish to see this developed and would be very keen to support the development of such a pathway.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.

218	SH	The Down's Syndrome Association	3	General	The RCOG need to reframe their guidance around pregnancies which involve a diagnosis of a fetal anomaly as these are currently titled “Termination for Fetal Anomaly”. Reference to continuing the pregnancy is contained within the guide, but the title of this resource is unhelpful.	Thank you for your comment. The specifics of counselling, information and procedure are all covered by the Fetal Anomaly Screening Programme (FASP), which we will signpost in the guideline.
219	SH	The National Childbirth Trust	1 & 2	28 & 1	‘Women are now, on average, older when having their first baby (15.9 per 1,000 women are over 40)’. We are unsure why this particular statistic is highlighted as the text refers to ‘average’ age then moves straight on to quantify women over 40 (when the average is actually just over 30). In addition, we feel it is misleading that the ratio is presented with 1,000 as denominator, whereas in successive paragraphs (eg lines 5-16) percentages are used. It has the effect of overstating the proportion of pregnancies in older women.	Thank you for your comment, we have changed the figures accordingly.
220	SH	The National Childbirth Trust	2	8 to 10	“Around 41% [of women] were offered a choice of a midwife-led unit or birth centre. These findings are in line with the recommendations from Better Births.” In fact, Better Births (recommendation 1.4) says ‘Women should be able to make decisions about … where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit’ so to imply that 41% is ‘in line’ with this is inaccurate: the aim is ‘most women’, not less than half.	Thank you for your comment. The percentage of women accessing care directly through a midwife and those being offered choice of place of birth has increased in line with better births.
221	SH	The National Childbirth Trust	4	21	It is unclear why the guideline will only look at “inequalities relating to disability (cognitive or neurological)”. There is very little extra detail in the Equality Impact Assessment. It is important that inequalities are specifically addressed such as sensory or physical disabilities, teenage mothers, gender reassignment, religion, migrants and refugees, and British born women of colour. On P2, line 1-2, it is acknowledged that “over a quarter of mothers are born outside the UK” and the latest MBRRACE report states: “The rate of maternal mortality was higher amongst older women, those living in the most deprived areas and amongst women from particular ethnic minority groups” (https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202017%20-%20Web.pdf page 15). It is important that all guidance from NICE specifically addresses the access these groups have to maternity services.	Thank you for your comment. We agree that the areas you mention are significant factors to consider during antenatal care. The reason why they are not covered in the equality impact assessment is because they are explored in the pregnancy and complex social factors NICE guideline. For further details please see CG110

						https://www.nice.org.uk/Guidance/CG110
222	SH	The National Childbirth Trust	6	15	This states that screening for preterm birth will not be included in the guideline. However the section 'current practice' (p3, lines 3-6) outlines models of care that have been introduced to reduce the risk of preterm birth. We are unclear on whether NICE considers these two sections to be covering separate issues and would like to see some clarification.	Thank you for comment. We have removed the section you refer.
223	SH	The National Childbirth Trust	9	8	"What information do partners and families value as part of antenatal care?" We welcome the inclusion of partners' concerns in this draft scope.	Thank you for your comment.
224	SH	The National Childbirth Trust	9	30	We regularly hear from women that their due date has been changed following ultrasound, even when they are very sure of their conception date (eg, it is an IVF pregnancy). Given the steady increase in induction of labour for reasons such as prolonged pregnancy and babies who are thought to be small for gestational age (when this is based on initial scan data) we feel this issue should be part of an evidence review.	Thank you for your comment. The points you make will be considered by the committee during the development of the protocols for the evidence review questions on determining gestational age.

225	SH	The National Childbirth Trust	9 to 11	3	This section should include antenatal planning for postnatal care and support. This is crucial to ensure that: important notes are passed from antenatal to postnatal care teams women are encouraged to think about what they may need in terms of both information and support after the birth. NCT is currently conducting a parent insight project and one of the emerging themes is that parents-to-be, particularly first timers, often don't recognise the need to identify and build support networks before their baby is born. They consequently struggle in the postnatal period and don't know where to turn for help. the midwife offers information about how postnatal care is provided both in hospital and in the community	Thank you for your comment. We note that the update of CG37 will include the following evidence review question: "What is the essential content of the postnatal care contacts for women and babies?" . For further information please see: https://www.nice.org.uk/guidance/CG37.
226	SH	The National Childbirth Trust	9	14-21	The focus of this draft scope appears to be very narrow, looking at the effectiveness of antenatal classes and the timing and frequency of 1-1 appointments. There are gaps in support and information transmission that do not fit easily into antenatal appointment schedules. There could be an opportunity to improve cost effectiveness by looking more broadly at evidence on effective approaches to promoting healthy behaviours, particularly in early pregnancy, and how NHS resources can be used most effectively in facilitating this. From NCT's Insight project, we know that parents feel there is a big gap in support in early pregnancy. It may be useful to examine the evidence on interventions such as facilitated drop-ins, and sessions delivered by maternity support workers and peer supporters.	Thank you for your comment. The committee will consider this when developing the evidence review protocols for information and support. The different types of support - including facilitated drop-ins and sessions delivered by maternity support workers - will be reflected in the detail of the review protocols. We anticipate the type of evidence you have suggested would be located by the proposed review questions on peer support and antenatal classes and groups, which will be broadly defined.
227	SH	The National Childbirth Trust	10	1to7	With regard to this section, it would be good to see consideration of any advice or interventions that reassure parents that their baby is growing well.	Thank you for your comment. We cannot pre-empt recommendations at this stage, but we will be

						conducting evidence reviews on monitoring fetal growth and wellbeing.
228	SH	The National Childbirth Trust	10	24-33	We were very surprised that there is no specific mention of testing for Group B Streptococcus in this draft scope. This is an area of interest for many parents, particularly those who have been affected in previous pregnancies. The publication of the RCOG Greentop guideline on GBS, in September 2017, means there is good quality, up to date evidence available on the topic https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg36/ and this should be referenced in the scope.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
229	SH	The National Childbirth Trust	11	4	Interventions for common problems during pregnancy – we welcome the inclusion of this section.	Thank you for your comment.
230	SH	The Ups of Downs and Positive about Down syndrome	9	11	Information for those with Additional Support Needs, needs to be considered and dealt with sensitively in accordance with equality guidance.	Thank you for your comment. The point you make will be considered by the committee during the development of the protocols related to information and support and we would expect it to arise in the qualitative evidence about the views and experiences of women and their families. The importance of ensuring tailored support is also reflected in the Equalities Impact Assessment for this guideline..

231	SH	The Ups of Downs and Positive about Down syndrome	4 General	16 General	As above, CG62 has to be reviewed in accordance with equality guidance framework, for compliance (Public Health equality duties). Language must be sensitive to people with disability.	Thank you for your comment. Please see the associated Equalities Impact Assessment for this guideline. The committee will consider adjusting language where necessary during the development of recommendations.
232	SH	The Ups of Downs and Positive about Down syndrome	5	9 10	Nuffield Bioethics Council has recommended the development of a new guideline for women continuing with pregnancy following news of a congenital condition. It is critical that these women receive support to ensure wellbeing during pregnancy (anxiety in mothers is not good for developing babies). Thankfully, this issue has now been highlighted by the right people and will become more relevant when prenatal; screening programmes are expanded to include lots of conditions. Provision of that guideline will become even more relevant as additional conditions are identified.	Thank you for your comment. We expect that screening and management of fetal anomaly will be covered by Fetal Anomaly Screening Programme (FASP) which will be signposted in the guideline recommendations.
233	SH	The Ups of Downs and Positive about Down syndrome	5	9 10	The scope must include review of guidance around the Fetal Anomaly scan. This information must be developed further in this review in order to ensure that sensitive, appropriate advice and support is offered when any condition is detected.	Thank you for your comment. We expect that screening and management of fetal anomaly will be covered by Fetal Anomaly Screening Programme (FASP) which will be signposted in the guideline recommendations.

234	SH	The Ups of Downs and Positive about Down syndrome	11	32	Want to bring to your attention that no benefit ensues re uptake of screening and this shouldn't be a main consideration 'outcomes'.	Thank you for your comment. To clarify, uptake of screening is not described in the draft scope as a main outcome.
235	SH	The Ups of Downs and Positive about Down syndrome	General	General	The CG62 guidance review carried out in 2011 asserted that inconsistencies between UK National Screening Committee standards for screening for Down's syndrome and fetal anomalies and guideline recommendations would be taken into account in the next CG62 review	Thank you for your comment. We expect that screening and management of fetal anomaly will be covered by Fetal Anomaly Screening Programme (FASP) which will be signposted in the guideline recommendations.

236	SH	Tommy's	General	General	38% of births are to first time mothers, yet 46% - 50% of stillbirths and preterm births are to first time mothers making them a high risk group in their own right. We have over relied on previous obstetric history to assess risk. Could this guideline please consider what more could be done to reduce preterm birth and stillbirth in this group; specifically how GPs and midwives work together to identify and manage women with underlying health issues in pregnancy and those who smoke and/or are obese, together with older mums.	Thank you for your comment. Reducing pre-term birth will be one of the outcomes that the committee will consider throughout the development of protocols for this guideline.
237	SH	Tommy's	General	General	It would be good to include guidance on providing information for EOGBS infection including what information is provided, when and by whom.	Thank you for your comment. Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline.
238	SH	Tommy's	General	General	Tommy's would be happy to share considerable expertise on the provision of pregnancy information to women including evidence of behaviour change and evidence of reach to women.	Thank you for your comment and for your offer of data.
239	SH	UK National Screening Committee's	3	22	Section on NSC should be amended to 'the NSC has reviewed the evidence and made a recommendation not to screen for certain conditions'	Thank you for your comment. This text has been amended.
240	SH	UK National Screening Committee's	3	19	Possibly include reference to DES programme in pregnancy too	Thank you for your comment. This is covered by the diabetes in pregnancy guideline.

241	SH	UK National Screening Committee's	3	26	Add influenza and PHE Management of Rash Illness in Pregnancy and Green Book	Thank you for your comment. We have revised this section accordingly.

242	SH	UK National Screening Committee's	3	23	Asymptomatic bacteriuria is a bit more complicated issue. The UK NSC had concerns that the evidence relating to screening was unclear. But the recommendation itself refers to whether a nationally managed programme structure should be introduced. The recommendation took into account that there was a NICE rec and the current practice is to test/screen. If NICE are moving away from making a recommendation in this area the UK NSC will need time to consider whether continuation or withdrawal of the screening should be recommended. Our recommendation is due for review in 2019/20	Thank you for your comment. We have added a note acknowledging that you, the NSC, are currently undertaking an evaluation for screening related to this key area. We have explained that we will liaise with the you to determine whether an evidence review will be required to complement your evaluation.
243	SH	UK National Screening Committee's	11	1	*9.1 What regimens for identifying blood group, rhesus D status and red cell alloantibodies, and for testing cell-free fetal DNA, are effective and safe for the mother and baby?* *There may be some uncertainty about the cost effectiveness of cfDNA testing.* *The UK NSC is evaluating whether the introduction of a nationally managed programme structure would* *a) bring an advantage in terms of the delivery of the screening and onward management and* *b) whether this would be cost effective.* *Our first estimate is that a nationally managed programme structure would bring little advantage as the screening and onward managed are delivered to a high standard. This was the conclusion of the recent audit of practice. The effect of this is that introducing a nationally managed programme structure would not be cost effective.*	Thank you for your comment. The scope has now been revised and no longer makes specific reference to 'blood group, rhesus D status and red blood cell antibodies'. Instead, the review question is about the effectiveness of screening for asymptomatic bacteriuria during pregnancy. However we have also added a note acknowledging that you, the NSC, are currently undertaking an evaluation for screening related to this key area. We have explained that we will liaise with the you to determine whether an evidence review will be required to

						complement your evaluation.

244	SH	UK National Screening Committee's	10	1	Monitoring fetal growth and wellbeing 1 4.1 What techniques (for example, symphysio fundal height measurements and ultrasound) are effective in monitoring fetal growth during pregnancy? 4.2 What techniques (for example, fetal movement reporting and ultrasound) are effective in monitoring fetal wellbeing, and identifying problems, during pregnancy? The UK NSC is currently undertaking an evaluation of screening for Stillbirth In our review we have a monitoring question that will look at Fetal movements and Fetal growth	Thank you for your comment. We have added a note acknowledging that you, the NSC, are currently undertaking an evaluation for screening related to this key area. We have explained that we will liaise with the you to determine whether an evidence review will be required to complement your evaluation.
245	SH	UK National Screening Committee's	10	9	"What is the effectiveness of performing routine blood tests to assess haemoglobin and iron status during pregnancy? This is a screening recommendation and will be reviewed by the UKNSC.	Thank you for your comment and for the information about your research. This guideline will signpost the relevant advice.

246	SH	UK National Screening Committee's	10	28	Screening for susceptibility to rubella infection ceased on 1 April 2016. Should the draft scope note this?	Thank you for your comment and for the information about your research. This guideline will signpost the relevant advice.
247	SH	UK National Screening Committee's	General	General	The rationale given for updating the guideline seems a bit inconsistent with the purpose of the document itself. It states that more women are giving birth at an older age, more are obese etc. (pg. 1-2), however it seems that these pregnant women are in fact not the ones the guideline is targeted at. Women of advanced maternal age (for example) already have their pregnancies classified as high risk and so are not 'uncomplicated'. It also not clear how decisions were made about which areas of guidance will stay and which are being scrapped, as some of those being scrapped seemed valuable.	Thank you for comments. The 2008 NICE antenatal guidance will be stood down once this guideline is published
248	SH	UK National Screening Committee's	General	General	We welcome the signposting to UK NSC recommendation on screening related issues and policy and the NHS screening programmes pathways and guidance for antenatal screening	Thank you for comments. The 2008 NICE antenatal guidance will be stood down once this guideline is published
249	SH	University hospital Southampton	11	Section 10	Interventions for common problems during pregnancy – also consider itching or rash, minor respiratory tract infection	Thank you for your comment. We acknowledge that the list of 'common problems' is not exhaustive and was drawn up through a process of prioritisation by the scoping group focusing on those of potential major importance or those in which there is significant evidence. We consider that rash is a symptom, not a disorder and could have many causes and thus, is not suitable for an evidence

						based scoping question. The management of minor respiratory tract infection is no different in pregnancy and will not be prioritised for inclusion in the guideline.
250	SH	City, University of London	9	6	What information about place of birth should be given to women during antenatal care, and what is the best time/way to deliver such information?	Thank you for your comment. The point you make will be considered by the committee during protocol development for the evidence review questions on information and support for women and their families.
251	SH	City, University of London	9	15	Where is the best location for delivering antenatal care (primary care/'community hubs'/hospital)	Thank you for your comment. The point you make will be considered by the committee during the development of the protocols for the evidence review questions on content of antenatal care appointments.
252	SH	City, University of London	9	15	What is the best way to provide support to women who speak little or no English?	Thank you for your comment. The importance of ensuring tailored support for women who speak little or no English is also reflected in the Equalities Impact Assessment for this guideline. The committee will consider adjusting language where necessary

						during the development of recommendations.
253	SH	City, University of London	9	15	What is the best way to support fathers during the antenatal period, and what are their needs?	Thank you for your comment. Your suggestion about the support of fathers during the antenatal period will be covered in the guideline as part of evidence review questions on information and support.
254	SH	City, University of London	9	15	What is the best way to assess and measure psychological wellbeing/vulnerability to facilitate identification and appropriate planning and referral (4-Tier system used by GPs and Social Services or Universal/Universal Plus/Universal Partnership Plus used by Health Visitors?). There is currently no formal system for measuring vulnerability in maternity which makes it difficult for midwifery services to measure the vulnerability of their caseloads and makes communication with other services difficult. The Lambeth Early Action Partnership (LEAP) Health Team is developing a maternity-based version of the 4-Tier assessment.	Thank you for your comment. As part of the area on content and delivery of antenatal care we will be looking at effectiveness of the different methods to access antenatal care. The committee will consider your comment during the development of the protocol.
255	SH	City, University of London	9	19	And what frequency/timing of appointments would be preferred by women?	Thank you for your comment. The points you make about the frequency/timing of birth will be considered by the committee during the development of the protocol for the questions on the content and delivery of antenatal care.

256	SH	City, University of London	9	21	We feel it would be useful to review the evidence on alternative modes of antenatal care, for example group antenatal care. Women often mention how hard they find the long gaps between appointments in early pregnancy.	Thank you for your comment. The committee will consider your comment during the development of the protocol for the questions on the content and delivery of antenatal care.
257	SH	City, University of London	9	22	We feel it is important to review the evidence of effectiveness of antenatal continuity of care (i.e. without an intrapartum element) – there is no evidence about this at present and many Trusts are developing models which improve antenatal (but not intrapartum) continuity.	Thank you for your comment. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. in the NICE guideline on patient experience in adult NHS services (CG138). The guideline can be found here https://www.nice.org.uk/Guidance/CG138

258	SH	City, University of London	10	2	What should women be told about the reliability of growth scans at 36 weeks and should women's characteristics (weight, ethnicity) be taken into consideration when considering a baby's growth?	Thank you for your comment. Evidence on the estimation of gestational age by ultrasound will be reviewed as part of this guideline. In addition, information about growth scans will be covered by the questions on information and support for women and their families, in particular on what information should be provided.

259	SH	City, University of London	10	5	What interventions / care bundles are most effective in reducing pre-term birth (caseloading, group antenatal care, Affirm, GROW etc.)	Thank you for your comment. The committee will prioritise interventions of interest during protocol development for the content and delivery of antenatal care
260	SH	Fatherhood Institute	General	**Fathers' impact prenatally – in relation to MENTAL HEALTH -** an extract from a forthcoming Fatherhood Institute review of the UK literature (Nuffield Foundation funded) - *Who's the Daddy? British fathers in the*	There are a number of Alspac analyses available which link fathers' pre-natal depression and/ or anxiety to later child outcomes, although it is quite likely that the most severely affected fathers were not identified and included in this aspect of the study. Nevertheless, correlations were found between expectant fathers' depression and child outcomes subsequently. These include more emotional, conduct, and total problems (Hanington et al., 2012), attention difficulties (Van Batenburg-Eddes et al., 2013) and behavioural/ emotional/ psychiatric problems, especially in boys and through to age seven, controlling for their fathers' postnatal and concurrent depression (Ramchandani et al., 2008). (Unsurprisingly, chronicity and fathers' depression postnatally were even more strongly associated with negative child outcomes). The evidence on the impact of fathers' prenatal mental health illustrates the interdependence of the couple and the profound impact that indirect effects can have. 'Genetic risks' (from father to child) cannot be ruled out., of course . However, although these were not identified in the Alspac sample, they are not likely to be significant: depressive disorders are less strongly 'heritable' than, for example, schizophrenia and bipolar disorder (Sullivan, 2012). The finger points clearly to indirect effects: when the expectant Alspac fathers were depressed the couples argued more, and their conflict was not only independently linked with the children's later difficulties but also moderated the impact of the father's depression on them (Hanington et al., 2012). In addition it is possible that the father's depression caused or exacerbated the mother's emotional difficulties (Ramchandani & Psychogiou, 2009), and there is good evidence that expectant mothers' stress, anxiety, and depression can have long-term effects on a variety of child outcomes (Glover et al., 2016), possibly through fetal programming. The expectant fathers' poor mental health may also have compromised their employment, and this might have caused financial or housing difficulties (Ramchandani & Psychogiou, 2009), distressing both parents and aggravating conflict.	Thank you for your comment. We recognise the importance of supporting fathers during the antenatal period and this is reflected in the question under key area 1 about what support and information partners and families value during this period. However in light of yours and other stakeholder comments about engagement of fathers the scope has also been revised with an additional question on 'What approaches are effective in involving partners during antenatal?'. Many of the factors you describe, such as physical and emotional outcomes for children will be considered by the committee during protocol development.

				antenatal period and at the birth (footnotes removed for reasons of length here, but available on request)	Fathers' impact in families (and mothers' also) can often be through their impact on the other parent: analyses of a smaller-scale Alspac pilot (Dragonas et al., 1992; Thorpe et al., 1992) explored correlations between fathers' prenatal mental health and their later supportiveness of mothers, as well as their reaction to fatherhood and their levels of involvement with, and enjoyment of, their infants once born. Poor mental health in fathers before the birth was linked negatively with all of these; and all these factors may well impact on child adjustment and behaviour later, both directly and indirectly. When Alspac mothers had reported cruelty by their partner or no support or affection from him during pregnancy, their children were more likely to experience chronic and disabling fatigue thirteen years later (Crawley et al., 2012).	
261	SH	Royal College of General Practitioners	General		Continuity of care will not be looked at but there is evidence that having the same midwife throughout the pregnancy gives a more favourable outcomePossible cost savings 1. Reducing hospital appointments 2. Self monitoring of blood pressure using home BP machines 3. Use of patient on line as well as email communication from pregnant woment to midwives 4. Use of health care assistants to test urine and data input 5. Use of prefilled questionaires before antenatal visits 6. Use of pregnancy app with trusted video and other patient information to promote self care	Thank you for your comment and information. No further evidence reviews on continuity of carer will be undertaken and the guideline will refer to existing relevant NICE guidance. For further guidance on ensuring continuity of care, please see section 1.4. in the NICE guideline on patient experience in adult NHS services.
262	SH	Royal College of General Practitioners	General		There is no reference to the WHO guidelines 2016 recommendations on antenatal care for a positive pregnancy experience http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/	Thank you for your comment, we will be conducting an evidence review on what women value as part of their antenatal care. In the guideline scope, under 'related' guidance, it is only

						NICE guidance that is listed.
263	SH	Royal College of General Practitioners	General		There are no recommendations about the involvement of men in antenatal care. From 2015 WHO recommendations on health promotion interventions for maternal and newborn health Interventions to promote the involvement of men during pregnancy, childbirth and after birth are recommended to facilitate and support improved self-care of women, improved home care practices for women and newborns, and improved use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns. (Strong recommendation, very low-quality evidence.) These interventions are recommended provided that they are implemented in a way that respects, promotes and facilitates women's choices and their autonomy in decision-making, and supports women in taking care of themselves and their newborns. In order to ensure this, rigorous monitoring and evaluation of implementation is recommended.	Thank you for your comment. Evidence on how to engage partner/fathers in the context of antenatal care will be looked at in this guideline, particularly under the key area of information and support for women and their families. Please note that in light of yours and other stakeholder comments on this issue, a specific question about involving partners during antenatal care has been added.