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Association of Anaesthetists	008	003	Establishing and maintaining regional analgesia (2007): There is significant literature on the new method of maintaining epidural analgesia with Programmed Intermittent Epidural Bolus (PIEB). This section should be updated [1.9.19].	Thank you for your comment. We have added a review of the use of Programmed Intermittent Epidural Bolus to the review questions which will be included in this update.
BAME Health Collaborative	011 - 012	Ongoing assessment (and criteria for transfer to obstetric-led care) (2014)	Capacity of the obstetric unit will need to be taken into account. It is very difficult for available capacity to be foreseen as the clinical picture develops during a shift.	Thank you for your comment. We agree that for a transfer to occur the receiving obstetric unit will need to have capacity to receive the women but this is an operational issue which would be discussed at the time of transfer and not something that would be covered by NICE guidelines.
BAME Health Collaborative	012 - 013	Intravenous and intramuscular opioids (2007)	If a decision is made for intravenous PCA, Trusts should be mindful that one to one care and continuous monitoring will be required hence this could impact on staffing issues especially in early labour.	Thank you for your comment. We will take into account the impact of any recommendations that are made, and this will be discussed in the relevant evidence review.
BAME Health Collaborative	002	026 - 028	These include the report of the National Maternity Review 'Better Births' which was published in 2016 and the subsequent Maternity Transformation Programme (MTP) **and more recently the Ockendon Report (2020).**	Thank you for your comment. This section of the guideline refers to national policy documents, but we have included the Ockendon review

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				in a later paragraph referring to 'lessons learnt reports'.
BAME Health Collaborative	002	008 - 009	In addition to this, adequate support for the woman **from her carers** and good communication during labour can optimise outcomes and	Thank you for your comment. In NICE documents the term 'carers' usually means informal carers such as other family members or friends, and in the context of this part of the scope we meant support from healthcare professionals, so we have not made this change.
BAME Health Collaborative	003	017- 018	In 2020, the Ockendon Report recommended that women and their families are listened to and their voices heard; and undergo a risk assessment at each contact during the intrapartum care. It is recommended that staffs who work together must train together. This promotes better teamwork and patient safety.	Thank you for your comment. The Ockendon Report has now been included in this section of the scope, and the committee will be aware of its findings and recommendations when revising this guideline.
BAME Health Collaborative	004	026 - 028	The data is available as it is captured in the demographic history obtained from all patients at booking. The social determinants of health play a critical aspect in the outcome of pregnancies. The BAME group is not homogenous and distinction should be made between the ethnic groups rather than placing them under one	Thank you for your comment. We appreciate that the BAME group is not homogenous and that NHS organisations will be best placed to identify the

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			umbrella. Trusts should engage the services of data analysts to create cause groups or classification that will highlight these women. Women from deprived socioeconomic group should have their social needs identified in the antenatal period and a plan drawn by the social services department in partnership with relevant stakeholders to meet these deficiencies.	ethnic and socioeconomic groups that they serve in their population and adjust the provision of their services accordingly. However, the phrase 'if it is available' in this context meant in the evidence base which will be used to answer the reviews questions. Some evidence will allow a sub-group analysis of women by different ethnic groups and so allow different recommendations to be made for these groups, where appropriate.
BAME Health Collaborative	004	010	Basically any woman and her family that has protected characteristics as stated in the Equalities Act 2010 should have individualised risk assessment.	Thank you for your comment. We agree that any woman with any protected characteristics may need special consideration. The categories stated in this part of the scope are given as example only.

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BAME Health Collaborative	013	Measuring fetal heart rate (2017)	BAME HC recommends that physiological interpretation of CTG be part of the guideline	Thank you for your comment. We plan to make editorial changes to the wording of the CTG recommendations in the guideline to aid implementation, as described in the scope, and will consider the role of physiological CTG interpretation
BAME Health Collaborative	014	Fetal blood sampling (2017)	Can this be reconsidered in light of the current evidence that shows the sampling result is not representative of the fetal condition and most times is contaminated by liquor?	Thank you for your comment. We think this refers to page 8, not page 14. We are aware of the variation in practice and possible confusion with the recommendations on fetal blood sampling and a question on the usefulness of fetal blood sampling is now planned for inclusion in the guideline update..
Birth Trauma Association	004	026	It would be useful to include younger mothers as a subgroup. The under 21s were considered as a specific sub group in the postnatal guideline because their requirements for support in particular are so different, so that might be worth doing here.	Thank you for your comment. We recognise that there may be some differences in antenatal care and postnatal care for young pregnant

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				women (and these are covered in the 'Pregnancy and complex social factors guideline and the Postnatal care guideline respectively) but that there is less likely to be a difference in Intrapartum care. However, we will consider this group separately if we identify specific questions where a sub-group analysis for this group is considered necessary, or where amendments to the recommendations are required.
Birth Trauma Association	006	008	The guideline says that when it comes to choosing place of birth, NICE will retain recommendations from the existing 2014 guideline. The evidence on which the previous recommendations were made is out of date because it was based on services that have now been reconfigured. The evidence specifically stated that the results were a snapshot in time and would not apply if reconfiguration of services occurred.	Thank you for your comment. The recommendations made in 2014 took into consideration the development of a greater number of freestanding midwifery units and there has been no additional reconfiguration of services. However, it is planned to carry

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				out an editorial review of this section of the guideline to ensure the recommendations are consistent with current practice (for example, siting of intravenous lines and administration of intravenous antibiotics by midwives).
Birth Trauma Association	006	008	We were concerned that there is to be no evidence review of women's experiences, retaining instead recommendations from 2014. We feel it would be worth looking at the evidence of the last seven years.	Thank you for your comment. Women's experiences (such as satisfaction and quality of life) will be considered as outcomes for reviews when updating this guideline, but it is not planned to update the section on women's experience as we have not identified any evidence that would lead to a change in these recommendations. However, editorial changes may be made to the wording to bring them more in-line with current NICE terminology.

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Birth Trauma Association	006	008	We were concerned that there is to be no evidence review of communication, retaining recommendations from 2007, which are now 14 years old.	Thank you for your comment. it is not planned to update the section on communication as we have not identified any evidence that would lead to a change in these recommendations. However, editorial changes may be made to the wording to bring them more in-line with current NICE terminology
Birth Trauma Association	011	005	In the reference to 'non-clinical interventions to reduce unnecessary caesarean birth' we felt it would be helpful to have a definition of 'unnecessary' caesarean birth.	Thank you for your comment. We have changed 'unnecessary' to 'unplanned',
British Maternal & Fetal Medicine Society	-	-	The section on fetal blood sampling as in current CG 190 section 1.10.40- 1.10.44 has not been included in the scope.	Thank you for your comment. The section on fetal blood sampling is included in the proposed outline for the guideline table in the consultation version of the scope, but this table explains that the recommendations from the existing guideline will be retained. However, following other stakeholder

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				comments, a question on the usefulness of fetal blood sampling is now planned for inclusion in the guideline update.
British Maternal & Fetal Medicine Society	013	016 - 020	These questions relate to the dose of intravenous oxytocin and what the optimum dose should be when it is restarted but no rationale or evidence is provided as to why. If the rationale is based on the HOLDS trial results being ready the trial is due to re-start in the autumn this year and will complete in 2023-24.	Thank you for your comment and for the information on the HOLDS study. The rationale for this review question was due to uncertainty in this area, and a systematic review will be conducted to identify all evidence that will help address this uncertainty.
Ferring Pharmaceuticals Limited	010	n/a	'Review evidence: update existing recommendations as needed - risks of active management, route of administration of oxytocin; use of carbetocin or other uterotonics, delayed cord clamping and new question on placement of the baby during delayed cord clamping' We will request for the NICE Committee to take into consideration the latest published information on carbetocin when updating guidance regarding use of carbetocin: Carbetocin indication and formulation updated since last review (now includes use in both vaginal and Caesarean deliveries):	Thank you for your comment. We will be undertaking a systematic review to identify the evidence for the use of carbetocin in the prevention of post-partum haemorrhage, but thank you for highlighting these recent changes to the prescribing information.

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			• 'PABAL is indicated for the prevention of postpartum haemorrhage due to uterine atony.' Route of administration for carbetocin updated since last review (Vaginal deliveries – intramuscular and intravenous, Caesarean section – intravenous only): • 'Posology Caesarean section under epidural or spinal anaesthesia: Withdraw 1 ml of PABAL containing 100 micrograms carbetocin and administer only by intravenous injection, under adequate medical supervision in a hospital. Vaginal delivery: Withdraw 1 ml of PABAL containing 100 micrograms carbetocin and administer by intravenous injection or intramuscular injection, under adequate medical supervision in a hospital.' • 'Method of administration For intravenous or intramuscular administration. Carbetocin must only be administered after delivery of the infant, and as soon as possible after delivery, preferably before the delivery of the placenta. For intravenous administration carbetocin must be administered slowly, over 1 minute.	

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			PABAL is intended for single use only. No further doses of carbetocin should be administered.' Storage recommendations updated since last review (formulation changes from refrigerated to room temperature): • 'Keep vials in the outer carton, in order to protect from light. Store below 30°C. Do not freeze.' Reference: Pabal 100 micrograms in 1ml solution for injection Summary of Product Characteristics. Available: https://www.medicines.org.uk/emc/product/172/smpc (last accessed on 01-Feb-2021)	
Ferring Pharmaceuticals Limited	014	009 and 010	'5.3 What is the effectiveness of uterotonics (for example, oxytocin and carbetocin) for the prevention of postpartum haemorrhage?' We will request for the NICE Committee to take into consideration the latest published information on the effectiveness of uterotonics: **1. WHO Guidelines:** a. World Health Organization. WHO Recommendations. Uterotonics for the Prevention of Postpartum Haemorrhage. 2018. Available: https://apps.who.int/iris/bitstream/handle/10665/277276/9789241550420-eng.pdf?ua=1 (last accessed on 01-Feb-2021)	Thank you for your comment. We will be undertaking a systematic review to identify the evidence for this review question but it is very helpful that you have identified these references for us, and we will consider whether they meet the review protocol.

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			b. World Health Organization. WHO Recommendations. Uterotonics for the Prevention of Postpartum Haemorrhage. 2018. Web annex 7: Choice of uterotonic agents. Available: https://apps.who.int/iris/bitstream/handle/10665/277283/WHO-RHR-18.34-eng.pdf?sequence=1&isAllowed=y (last accessed on 01-Feb-2021) 2. **Cochrane Network Meta-analysis:** Gallos ID, Papadopoulou A, Man R, Athanasopoulos N, Tobias A, Price MJ, Williams MJ, Diaz V, Pasquale J, Chamillard M, Widmer M. Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis. Cochrane Database of Systematic Reviews. 2018(12). Available: https://pubmed.ncbi.nlm.nih.gov/30569545/ (last accessed on 01-Feb-2021) 3. **Health Technology assessment:** Gallos I, Williams H, Price M, Pickering K, Merriel A, Tobias A, et al. Uterotonic drugs to prevent postpartum haemorrhage: a network meta-analysis. Health Technol Assess 2019;23(9). Available: https://pubmed.ncbi.nlm.nih.gov/30821683/ (Last accessed on 01-Feb-2021) 4. **CHAMPION Randomised Controlled Trial:** Widmer M, Piaggio G, Nguyen TM, Osoti A, Owa OO, Misra S, Coomarasamy A, Abdel-Aleem H, Mallapur AA, Qureshi Z,	

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			Lumbiganon P. Heat-stable carbetocin versus oxytocin to prevent hemorrhage after vaginal birth. New England Journal of Medicine. 2018 Aug 23;379(8):743-52. Available: https://pubmed.ncbi.nlm.nih.gov/29949473/ (last accessed on 01-Feb-2021) 5. **IMOX Randomised Controlled Trial:** van der Nelson H, O'Brien S, Burnard S, Mayer M, Alvarez M, Knowlden J, Winter C, Dailami N, Marques E, Burden C, Siassakos D. Intramuscular oxytocin versus Syntometrine versus carbetocin for prevention of primary postpartum haemorrhage after vaginal birth: a randomised double-blinded clinical trial of effectiveness, side effects and quality of life. BJOG: An International Journal of Obstetrics & Gynaecology. 2020 Dec 10. Available: https://pubmed.ncbi.nlm.nih.gov/33300296/ (last accessed on 01-Feb-2021) 6. **Randomised Controlled Trial:** Amornpetchakul P, Lertbunnaphong T, Boriboonhiransarn D, Leetheeragul J, Sirisomboon R, Jiraprasertwong R. Intravenous carbetocin versus intravenous oxytocin for preventing atonic postpartum hemorrhage after normal vaginal delivery in high-risk singleton pregnancies: a triple-blind randomized controlled trial. Archives of gynecology and obstetrics. 2018 Aug;298(2):319-27. Available:	

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			https://pubmed.ncbi.nlm.nih.gov/29916110/ (last accessed on 02-Feb-2021) 7. **International Consensus Statement:** Heesen M, Carvalho B, Carvalho JC, Duvekot JJ, Dyer RA, Lucas DN, McDonnell N, Orbach-Zinger S, Kinsella SM. International consensus statement on the use of uterotonic agents during caesarean section. Anaesthesia. 2019 Oct;74(10):1305-19. Available: https://pubmed.ncbi.nlm.nih.gov/31347151/ (last accessed on 03-Feb-2021) **Cost-effectiveness analysis:** Pickering K, Gallos ID, Williams H, Price MJ, Merriel A, Lissauer D, Tobias A, Hofmeyr GJ, Coomarasamy A, Roberts TE. Uterotonic drugs for the prevention of postpartum haemorrhage: a cost-effectiveness analysis. PharmacoEconomics-open. 2019 Jun;3(2):163-76. Available: https://pubmed.ncbi.nlm.nih.gov/30506157/ (last accessed on 01-Feb-2021)	
Group B Strep Support	-	-	After describing situations in which GBS colonisation was not recorded in maternity records which impacted care in early labour, HSIB recommended that "The Trust should communicate with mothers and their partners in relation to the increased risk of infection including GBS in labour and the neonatal period following pre-labour rupture of membranes."	Thank you for your comment. We agree that recording of GBS status and communication with women is important. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is

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			We support HSIB's recommendation and request that the scope is amended to ensure documentation is designed so that comprehensive information is easily recorded, including where a woman has any history of group B Strep in the current or previous pregnancy.	covered in other existing guidance, but editorial changes to the guideline are now planned to ensure there are suitable cross-references to facilitate the better management of GBS.
Group B Strep Support	-	-	There is no clear guidance about when a woman should be offered IAP against EOGBS infection developing in their baby. The RCOG's 2017 greentop guideline recommends that if they're indicated and the woman has agreed to have the IV antibiotics in labour, they should be given as soon as possible once labour has started, and at regular intervals until the baby is born: "For women who have agreed to IAP, benzylpenicillin should be administered. Once commenced, treatment should be given regularly until delivery. […] It is recommended that 3 g intravenous benzylpenicillin be given as soon as possible after the onset of labour and 1.5 g 4 hourly until delivery. To optimise the efficacy of IAP, the first dose should be given at least 4 hours prior to delivery." [RCOG GTG 36, Section 9.4, 2017]	Thank you for your comment. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is covered in other existing guidance, such as the RCOG greentop that you have referred to, but editorial changes to the guideline are now planned to ensure there are suitable cross-references to facilitate the better management of GBS. In respect of your comment on the definitions of the latent and active first stage of labour, we are aware that

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			In an ideal world, the first dose should be given at least 4 hours before the baby is born, though in reality particularly where it is not a first baby the time between the definition of labour and the baby being born does not allow >4 hours. This definition of painful contractions AND progressive cervical dilatation from 4cm means some women, particularly where it's not their first baby, aren't getting sufficient IAP before their babies are both, where they would perhaps if the definition weren't quite so advanced. We recommend that that the definition of latent and/or established labour is reviewed or that there is clarification included for where a woman has a history of GBS or current GBS carriage, so that the threshold for giving the first dose of IAP is low.	international definitions may have changed, and are also planning to undertake an editorial review of the definitions included in the current guideline.
Group B Strep Support	General	General	There is no clear guidance on when a woman with a history of group B Strep in the current or previous pregnancy are advised to attend at their birthing hospital or MLU to receive IAP. HSIB reported that "Investigations observed maternity triage services encouraging mothers to stay at home for as long as possible. In some cases, this was due to information not being shared between clinicians, the right questions not being asked by the call receiver or problems with the documentation of a mother's GBS status. RCOG guidance suggests	Thank you for your comment. We agree that ensuring that women receive intrapartum antibiotic prophylaxis where necessary is important. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is covered in other existing guidance, but editorial

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			that mothers identified as carrying GBS should be seen earlier to allow antibiotic therapy to be given." And later: "A recurrent theme in HSIB maternity investigations was delayed or missing IAP; 22 cases were identified in the HSIB GBS cohort." [National Learning Report – Severe brain injury, early neonatal death and intrapartum stillbirth associated with group B streptococcus infection. Healthcare Safety Investigation Branch, July 2020] https://www.hsib.org.uk/documents/229/hsib-national-learning-report-group-b-strep.pdf if We recommend that the scope is amended to include the information sought and provided by maternity triage services when a woman is in early labour, including where a woman has any history of group B Strep in the current or previous pregnancy.	changes to the guideline are now planned to ensure there are suitable cross-references to facilitate the better management of GBS.
Group B Strep Support	005	Table 8	Table 8 states that "Medical conditions and other factors that may affect planned place of birth (2007, updated 2014)" will not be updated. This would mean leaving point 1.1.10 Table 6 in the current guideline listing "Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended" as it is. When this recommendation was updated in 2014, only a minority of midwifery led units (MLUs) were able to offer intrapartum	Thank you for your comment. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is covered in other existing guidance, but editorial changes to the guideline are now planned to

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			antimicrobial prophylaxis (IAP) to women known to carry group B Strep than now. Since then the situation in the UK has changed, with IAP now being available at most MLUs. We are concerned that if this statement is not amended, it will lead to women being denied the full range of birthplace choices, as the option of giving birth in an MLU will not be discussed, despite most MLUs now being able to offer IAP. We recommend that this is reviewed with the clarification added that IAP can be offered in the majority of MLUs.	ensure there are suitable cross-references to facilitate the better management of GBS, and we will also discuss with the committee if Table 6 should be amended as you suggest.
Group B Strep Support	005	Table 8	Table 8 states that "Definitions of the latent and established first stages of labour (2007)" will not be updated. This would mean leaving the definition in the current guideline of established labour in section 1.3.1 as "Established first stage of labour – when: there are regular painful contractions **and** there is progressive cervical dilatation from 4 cm. [2007]". [my emphasis] This definition involving both contractions and progressive dilation means that some women, particularly non-primips, will not receive sufficient IAP against GBS before their baby is born – as labour is usually quicker in subsequent pregnancies. This will leave a subset of babies at raised risk of EOGBS infection, and will lead to further monitoring in hospital that could have been avoided if the woman had been given sufficient IAP.	Thank you for your comment. We are aware that definitions of the latent and active first stage of labour may have changed, and are planning to undertake an editorial review of the definitions included in the current guideline. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is covered in other existing guidance but editorial changes to the guideline are now planned to

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			We recommend that that the definition of latent and/or established labour is reviewed or that there is clarification included for where a woman has a history of GBS or current GBS carriage, so that the threshold for giving the first dose of IAP is low.	ensure there are suitable cross-references to facilitate the better management of GBS.
Group B Strep Support	005	Table 8	Table 8 states that "Education and early assessment (2014)" will be updated, specifying timeframe between a mother reporting possible PRoM and face to face clinical review." There is no mention in the relevant sections of the importance of checking the woman's group B Strep history or carriage status this/in a previous pregnancy or of the presence of other relevant risk factors for early-onset GBS infection developing in their baby. This is important information, which will help guide whether the mother is offered IAP in labour and also when she should be offered induction and IAP for PRoM. We recommend that this section is reviewed to include information about checking a woman's group B Strep history, carriage status, and risk factors for their baby developing early-onset GBS infection to ensure that IAP and/or induction of labour is offered in line with RCOG guidance.	Thank you for your comment. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is covered in other existing guidance, but editorial changes to the guideline are now planned to ensure there are suitable cross-references to facilitate the better management of GBS.
Group B Strep Support	006	Table 8	Table 8 states that *"PRoM (2007)" will not be updated."* There's no mention in the relevant section 1.11 in the current guideline of the importance of checking the woman's group B Strep	Thank you for your comment. The management of GBS has not been prioritised for inclusion in the scope of this

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			history or carriage status for this or a previous pregnancy. This information would impact when the woman should be offered IAP in labour and when she should be offered induction and IAP for PRoM. We recommend this information is updated to include recommendations for women carrying/with a history of GBS.	guideline as it is covered in other existing guidance, but editorial changes to the guideline are now planned to ensure there are suitable cross-references to facilitate the better management of GBS.
Hampshire Hospitals NHS Foundation Trust	006		One-to-one care paramount for labour and birth and immediate care afterwards – links with comments for page 10 below.	Thanks for your comment. One-to-one care is already recommended in the Intrapartum care guideline and this part of the guideline is not being updated.
Hampshire Hospitals NHS Foundation Trust	007	008	**>Pain relief (2014) - No evidence review: retain recommendations from existing guideline** **>Non-pharmacological analgesia (TENS) (2007) – No evidence review: retain recommendations from existing guideline.** The existing guideline for TENS pain relief was carried over from 2007 CG55 guideline. This was based on a systematic review by Carroll *et al*, 2005. Transcutaneous electrical nerve stimulation in labour pain: a systematic review. In 2009 a Cochrane review looked at similar data (Dowswell T, Bedwell C, Lavender T, Neilson JP (2009), 'Transcutaneous electrical	Thank you for your comment. We have reviewed the evidence you have identified but think that is unlikely to change existing recommendations for the use of TENS in established labour, so we have not prioritised a review of the evidence for TENS as part of this update. However, we recognise that

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			nerve stimulation (TENS) for pain relief in labour' concluded that "Although it is not clear that it reduces pain, women should have the choice of using TENS in labour if they think it will be helpful." Despite this conclusion current NICE guidance is that TENS should NOT be offered?. In 2011 a review paper discovered that there had been serious methodology problems with the majority of TENS research papers up to that date. In maternity care it has now become evident that our service users should be able to have their say, talk about and share their experiences. Advances in making quality improvements and improving safety in Maternity services currently uses 'Co-production' asking for the views and contribution of women and families in Maternity care. Better Births 2017 & 2020 documents promote choice and personalisation for women, listening to them and their views to improve maternity care for the future. During the Covid 19 pandemic many women have preferred to remain at home to birth their babies, TENS has supported this choice in providing them with a form of mobile, drug free pain relief that can be used for 'out of hospital settings' births as well as within (TENS companies have supported women and have made TENS much more affordable in order that they can purchase their own rather than hire machines).	some women may choose to obtain and use TENS, particularly in early labour, and the current recommendation wording may suggest this should not be condoned. We therefore plan to make an editorial change to the guideline to clarify this.

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			TENS has therefore enabled the provision of non-invasive, mobile and self-controlled pain relief for women in labour and is used extensively by women in the UK who, when asked, assess it favourable and say they would use it again. It is therefore pertinent to include women's experiences of using TENS for labour and birth and to include the whole empirical evidence such as Qualitative Research. The vision for maternity care focuses on women centred care with choice, control and promoting normality at its centre. This intrapartum guideline is for low risk, healthy women, thus emphasising the need to empower women to make choices and decisions regarding their care in labour, birth and immediately afterwards. Shawley (2011) 'Women's experiences of TENS for pain control in labour' (Doctoral research at The University of Southampton) used Interpretative phenomenological Analysis (IPA) to explore the in-depth experiences of 20 purposely selected women via one-to-one interviews. The analysis of verbatim transcripts revealed comprehensive findings. TENS was recognised as being part of a wider strategy for the maintenance of control in labour and normal birth for women. Prior to this, the research on TENS failed to consider women's individual experiences therefore this study aimed to redress this balance and has filled a "gap" in the knowledge base and in addition, the findings suggest that TENS was identified as an	

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			'enabling mechanism' for the women to be in control of a normal birth. Since 2011, at least 39 other papers have been published on TENS use for pain control in labour and their conclusions have all shown positive benefits. Evidence for TENS has not been reviewed since 2005. There is a substantial body of new evidence that should be reviewed taking into account Women's, midwives and researcher's new evidence regarding the use of TENS for labour, birth and afterwards. This guideline specifies that it includes all birthing environments, TENS is used widely in acute units, birth centres and home births promoting normal birth and supporting women with pain control, it therefore deserves to be recognised in the intrapartum guideline for normal birth.	
Hampshire Hospitals NHS Foundation Trust	010		Assessment of baby, bonding – The 'first hour of care' work is paramount to be re-visited as it is the key to promoting the best start and adaptation to life for the baby. Please consider this area. As no attachments are to be sent – please see the example in a National Learning Report (HSIB) – Neonatal Collapse alongside Skin-to-skin (page 17).	Thank you for your comment. We consider this an important issue and plan to carry out an editorial update of the recommendations on skin-to-skin contact to include advice on positioning and checking on the baby

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Healthcare Safety Investigation Branch	general	general	In August 2020, HSIB wrote to NICE with suggestions for the scope of the Induction of Labour guidance, which is being reviewed this year. HSIB receive a response for this letter in October 2020, where NICE wrote: 'NICE will consider addressing the following areas as part of the upcoming update of its guideline on intrapartum care in healthy women: • Clarity about the timeframe between a mother reporting possible prelabour ROM and face to face clinical review • Additional guidance on the use of intravenous oxytocin in the later stages of labour' HSIB thanks NICE in including these elements in the review of this current guidance.	Thank you for your comment. We welcome the input from HSIB.
Healthcare Safety Investigation Branch	003	013 general	We feel that in addition to ongoing lessons learnt from MBRRACE-UK, there are emerging themes from national and local reports of HSIB, an organisation founded by the DHSC in 2017. We undertake independent safety investigations for babies that meet the RCOG Each Baby Counts criteria in England. Our purpose is to improve patient safety through effective and independent investigations that do not apportion blame or liability. We do this by working with families	Thank you for your comment. We welcome the input from HSIB.

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			and trusts to understand the events that have occurred and to address areas where we have identified safety for mothers and their babies could be optimised in the future. Through our investigations, over 1300 completed to date, we have identified areas where we consider national guidance could offer clinical staff and mothers additional support about current best practice. In addition, we believe it is also useful for staff and mothers to understand those areas where there is currently no or little evidence to inform care.	
Healthcare Safety Investigation Branch	006	Proposed outline	**Definitions of the latent and established first stages of labour (2007).** Our reports have identified variation in how the definitions of latent phase and established first stage of labour are interpreted by staff. In some cases that we have investigated, this has led to a mother being discharged home when admission was indicated; or to monitoring of both mother and baby in the first stage of labour not being undertaken or commenced appropriately.	Thank you for your comment. W**e are** aware that international definitions of the latent and active first stage of labour have changed, and are also planning to undertake an editorial review of the definitions included in the current guideline, and how the risk assessment should be undertaken in women at the very early stages of labour to determine the best place of care.
Healthcare Safety Investigation Branch	006	Proposed outline	**Management of latent phase**: Whilst there is some guidance in the current NICE guideline on the education of mothers around what to expect in the latent phase, from	Thank you for your comment. W**e are** aware that international definitions of the

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			our investigations we have identified wide variation in the management of prolonged latent phase. There is often a lack of recognition that a 'prolonged' latent phase can be a risk factor for poor outcome. Staff would appreciate a discussion over what constitutes 'prolonged' in this case and how to manage a prolonged latent phase, which may include the offer of obstetric review and planning for labour; or change in plan for the required frequency and monitoring of the mother and baby.	latent and active first stage of labour have changed, and are also planning to undertake an editorial review of the definitions included in the current guideline.
Healthcare Safety Investigation Branch	007	Proposed outline	**Initial assessment of woman** HSIB investigations have identified variation in the initial assessment of mothers when they attend in labour. In some cases, this has resulted in women being given incomplete information about the safest place for the birth of their baby. Some HSIB investigations have found that when a mother receiving midwifery-led care (MLC) has several minor risk factors, the incremental effect of these minor risk factors is not considered. This has led to keeping women under MLC when transfer to obstetric -led care is indicated. HSIB considers further guidance is required to support staff in planning care in the context of multiple minor risk factors in addition to the current list of major risk factors.	Thank you for your comment. We will be undertaking an editorial review of the guideline to ensure that assessment of the incremental effect of several minor risk factors is taken into consideration when planning the best place of care.
Healthcare Safety Investigation Branch	007	Proposed outline	**Ongoing assessment (and criteria for transfer to obstetric-led care)** HSIB investigations have found that observations and fluid balance are not always plotted on charts, thereby trends in changing observations	Thank you for your comment. We will be undertaking an editorial review of this section of the guideline to ensure that

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			and visual triggers for escalation of the mother's care are not available for staff. Staff would welcome guidance on the optimal way to record observations to trigger escalation and transfer to obstetric-led care. In light of the recent preliminary Ockenden review, staff would welcome an emphasis on the information that is shared with mothers in order be able to make an informed choice about transfer of their care, in addition to a discussion about the clinical transfer criteria.	continuous risk assessment is undertaken to determine the best place of care. We will also be undertaking an editorial review of the section on communication to emphasise the need for shared decision-making.
Healthcare Safety Investigation Branch	007	Proposed outline	**General principles for transfer of care** HSIB investigations have found that when a mother under midwifery-led care has several minor risk factors, it can be difficult for staff to judge the incremental effect of these minor risk factors, this sometimes results in keeping women under MLC when transfer to obstetric-led care is indicated. HSIB considers further guidance is required to support staff in planning care in the context of multiple minor risk factors in addition to the current list of major risk factors.	Thank you for your comment. We will be undertaking an editorial review of the guideline to ensure that assessment of the incremental effect of several minor risk factors is taken into consideration when planning the best place of care.
Healthcare Safety Investigation Branch	007	Proposed outline	**Controlling gastric acidity** Given the national withdrawal of most H_2-receptor antagonists in the UK, HSIB would value adding in the option of proton pump inhibitors to the list of medication (H2-antagoinsts or antacids) for women who receive opioids or develop risk factors that make a general anaesthetic more likely.	Thank you for your comment. We will discuss with the committee and consider making an editorial change to the guideline to include proton pump inhibitors as an option for the control of gastric acidity.

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Healthcare Safety Investigation Branch	007	Proposed outline	**Inhalational analgesia** Entonox is a greenhouse gas which contributes a significant amount to the total NHS carbon footprint (Carbon Hotspots update for the health and care sector in England, Sustainable Development Unit 2016). HSIB would like NICE to consider discussing this information in the updated NICE guidance so that mothers can make an informed choice for pain relief options in labour.	Thank you for your comment. We will be making an editorial change to the guideline to make women aware of the environmental impact of Entonox.
Healthcare Safety Investigation Branch	008	Proposed outline	**Care and observations for women with regional analgesia** New guidance from the Association of Anaesthetists and the Obstetric Anaesthetists' Association recommends that women with an epidural during labour should have motor block assessed hourly (Yentis at al (2020) Safety guideline: neurological monitoring associated with obstetric neuraxial block . Anaesthesia (2020) doi:10.1111/anae.14993). HSIB consider that this new guidance should be included in NICE's recommendations on the care and observations for women with regional analgesia.	Thank you for your comment. The existing guideline provides recommendations on monitoring women with regional analgesia, and we note the reference you have supplied is a consensus guideline which suggests additional checks for motor blocks. We therefore plan to discuss with the committee whether an editorial amendment can be made to the current monitoring recommendations.

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Healthcare Safety Investigation Branch	008	Proposed outline	**Management of CTG traces** HSIB investigations have found examples of excellent multidisciplinary team-working during emergencies. Staff would welcome the addition of recognition that assistance from the full multidisciplinary team, including midwives and anaesthetists in addition to obstetricians, should be urgently summoned, if there is need for urgent intervention.	Thank you for your comment. We plan to make editorial changes to the wording of the CTG recommendations in the guideline to aid implementation, as described in the scope, and will consider extending the terminology used to encompass other members of the team,
Healthcare Safety Investigation Branch	008	Proposed outline	**Conservative measures** HSIB investigations have identified that the practice of administering intravenous fluids as a conservative measure in response to a suspicious CTG, is widely practiced. This occurs often even if the mother is not hypotensive (NICE 2017). Our investigations have found that this can contribute to maternal and neonatal hyponatremia, resulting in considerable morbidity for mother and baby. Staff would value clarity around the effectiveness of, and recommendations around, intravenous fluid (including fluid balance monitoring) for suspicious and pathological CTGs.	Thank you for your comment. We will be carrying out editorial revisions to update the recommendations on drinking, intravenous fluids and monitoring of urine output and fluid balance during labour to reduce the risk of hyponatremia.
Healthcare Safety Investigation Branch	008	Proposed outline	**Fetal blood sampling (FBS)** HSIB investigations have a identified variation in the practice of fetal blood sampling between different trusts in England. Many trusts appear to have abandoned the practice of fetal blood sampling. Staff on the ground would welcome a review of the evidence surrounding	Thank you for your comment. We are aware of the variation in practice with fetal blood sampling and a question on the usefulness of fetal blood

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			fetal blood sampling and a definitive evidence-based recommendation that would reduce this variation.	sampling is now planned for inclusion in the guideline update.
Healthcare Safety Investigation Branch	008	Proposed outline	**Fetal blood sampling (FBS)** Fetal blood sampling in the presence of significant meconium: The current NICE guidance is confusing to staff in that there is a recommendation that 'If significant meconium is present, ensure that healthcare professionals trained in fetal blood sampling are available during labour' (section 1.5.3); and another recommendation 'Do not carry out fetal blood sampling if the whole clinical picture indicates that the birth should be expedited' (section 1.10.40). In the opinion of HSIB, the presence of a pathological CTG trace (an indication for fetal blood sampling) in combination with significant meconium, is an indication to expedite delivery in the majority of cases, rather than performing an FBS. Moreover, section 1.10.41 goes on to say 'Be aware that for women with significant meconium fetal blood sample results may be falsely reassuring'. Staff would welcome consistency over the guidance around fetal blood sampling in the presence of significant meconium.	Thank you for your comment. We are aware that some of the recommendations on fetal blood sampling may have led to confusion and a question on the usefulness of fetal blood sampling is now planned for inclusion in the guideline update.
Healthcare Safety Investigation Branch	009	Proposed outline	**When a fetal blood sample cannot be obtained** Staff would welcome guidance about the maximum timeframe that FBS should be attempted, prior to abandoning the FBS in favour of expediting delivery.	Thank you for your comment. We are aware that some of the recommendations on fetal blood sampling may have led to confusion and a question

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				on the usefulness of fetal blood sampling is now planned for inclusion in the guideline update.
Healthcare Safety Investigation Branch	009	Proposed outline	**PRoM (Prelabour Rupture of Membranes)** HSIB investigations have identified a wide variation in the management of prelabour rupture of membranes at term (PRoM).This includes the provision of a face to face or telephone assessment; the information given to mothers both verbal or written; the advice to monitor temperature four hourly (which in itself maybe a late sign of developing infection); and the offer of immediate induction of labour in line with the RCOG's 2017 Green-top Guideline No. 36, 'Group B Streptococcal Disease, Early-onset' . Staff would welcome clarity around these points.	Thank you for your comment. The management of GBS has not been prioritised for inclusion in the scope of this guideline as it is covered in other existing guidance, but editorial changes to the guideline are now planned to ensure there are suitable cross-references to facilitate the better management of GBS. We are, however, including a question on the time interval from reporting PRoM to face-to-face assessment which we hope will provide guidance to staff on this aspect of PRoM management.

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Healthcare Safety Investigation Branch	009	Proposed outline	**Delay in first stage** Advice given in the current NICE 2017 guideline is to 'Offer the woman… hydration' in the event of delay in the first stage of labour. HSIB investigations have identified that in a few cases, mothers have been encouraged to drink large quantities of fluid in this situation, without concurrent monitoring of her fluid balance. This has contributed to maternal and neonatal hyponatremia, resulting in morbidity for mothers and babies. Staff would value some guidance of the quantities to aim for when discussing 'hydration' in this context as well as the recording of fluid balance and triggers for escalation.	Thank you for your comment. We will be carrying out editorial revisions to update the recommendations on drinking, intravenous fluids and monitoring of urine output and fluid balance during labour to reduce the risk of hyponatremia.
Healthcare Safety Investigation Branch	009	Proposed outline	**Duration of the second stage and definition of delay** Whilst NICE 2017 is clear about the expected duration of the active second stage of labour in nulliparous women, HSIB investigations have identified confusion amongst staff about the expected length of a passive second change, particularly if the mother does NOT have regional anaesthesia on board. Staff would welcome a discussion on the optimal total duration of the second stage.	Thank you for your comment. We are not aware of any new evidence which would allow an evidence-based update of these recommendations but we will consider if editorial revision of these recommendations could reduce confusion amongst staff.
Healthcare Safety Investigation Branch	009	Proposed outline	**Oxytocin in the second stage** HSIB investigations have found that there is a variation in the dosing regimen for oxytocin starting in the second stage. Staff would welcome guidance from NICE about the optimal dosing regimen when starting oxytocin for the first time in the second stage of labour.	Thank you for your comment. We are not aware of any new evidence which would allow an evidence-based update of these recommendations but

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				we will consider if editorial revision of these recommendations could reduce confusion amongst staff.
Healthcare Safety Investigation Branch	010	Proposed outline	**Postpartum haemorrhage - management** HSIB considers that the need for supplemental oxygen during a postpartum haemorrhage should be brought into line with recent guidance from the British Thoracic Society that recommends that women who suffer hypoxaemia due to an acute complication of pregnancy such as postpartum haemorrhage should receive oxygen therapy with a targe oxygen saturation of 94-98% (O'Driscoll BR, Howard LS, Earis J, et al. BMJ Open Resp Res 2017;4:e000170. doi:10.1136/bmjresp-2016-000170 13).	Thank you for your comment. We plan to undertake an editorial revision of this section of the guideline and include this information.
Healthcare Safety Investigation Branch	010	Proposed outline	**Postpartum haemorrhage - management** HSIB welcomes NICE's plan to update the management of postpartum haemorrhage with the addition of tranexamic acid for the treatment of women with postpartum haemorrhage. HSIB considers that the evidence for the use of tranexamic acid for the prophylaxis of postpartum haemorrhage is lacking and would welcome a discussion around this latter point in the updated guideline.	Thank you for your comment. As you point out, the evidence for prophylactic use of tranexamic acid is lacking, although we are aware of an ongoing trial. New evidence was identified by surveillance relating to its use in treatment only and so this is the aspect of its use we will be updating.

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Healthcare Safety Investigation Branch	010	Proposed outline	**Initial assessment of the newborn baby and mother–baby bonding** HSIB's National Learning Report (NLR) 'Neonatal collapse alongside skin-to-skin contact' (2020) supports NICE 2017 recommendations about the importance of skin to skin contact for both mother and baby. The NLR included investigations where babies' airways became obstructed, leading to need for resuscitation in babies who had otherwise been born in good condition. The NLR recommended that all babies should be routinely monitored while in skin-to-skin contact with the mother or father; and that checking that a baby's position is such a that a clear airway is maintained, by observing respiratory rate and chest movement, is important. The report further reiterated the recommendation that health professionals should 'always listen to parents and respond immediately to any concerns raised'. Reference to this report when discussing assessment of the newborn baby, would be valued by staff who look after mothers and babies.	Thank you for your comment. We consider this an important issue and plan to carry out an editorial update of the recommendations on skin-to-skin contact to include advice on positioning and checking on the baby
MidwifeExpert.com	003	023	No mention of charities / support groups	Thank you for your comment. Charities and support groups have been added as additional groups for whom the guideline may be relevant.
Mumsnet	General	General	The scope does not appear to cover women's experiences on postnatal wards in hospital, which falls under the intrapartum tarriff.	Thank you for your comment. We note that care on the

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			Women who give birth in hospital (or are transferred there while in labour) regard the postnatal ward as being a part of their birth experience and would have a common sense expectation that this Guideline would encompass this part of intrapartum care.	postnatal ward falls under the intrapartum tariff, but this topic is covered by a separate NICE guideline on Postnatal care.
NHS England and NHS Improvement	004	026	Support the careful consideration for subgroups to tailor approaches for those who may be at risk of health inequalities or require increased input or amended approaches.	Thank you for your comment.
NHS England and NHS Improvement	005	013	'all settings' – does this include non-maternity services such as accident and emergency where women may present and gain access in urgent situations to midwifery care?	Thank you for your comment. It was not possible to list all the unplanned places where, occasionally, women may give birth (such as in ambulances, in emergency departments, in transit to their planned place of birth) and these births may indicate that the birth is not low risk. However, it is hoped that the principles of intrapartum care would apply wherever the birth began, and that the woman would be transferred to a labour ward as soon as possible where care in accordance with this

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				guideline would continue to be delivered.
NHS England and NHS Improvement	006	006 - 010	Suggest amendment of the language used to reflect that these women may not have full access to a range of healthcare and derive the full benefit as currently this reflects a emphasis upon their situation being problematic which is not the case. Also this is broader than 'disabilities' and applies to a range of people at a range of ability levels who may need reasonable adjustments.	Thank you for your comment. We think this relates to lines 6 to 10 on page 4 (not page 6). We have amended the text as you suggest to state that these women may not have full access. We agree that any woman with any protected characteristics may need special consideration. The categories stated in this part of the scope are given as examples only.
NHS England and NHS Improvement	013	004	Given the breadth of the guidance will communication and broader aspects such as promoting healthy practices post-partum and tailored approaches for at risk and vulnerable groups be explored?	Thank you for your comment. An update of the communication section of this guideline is not planned as part of this update, but as part of the editorial update we will be updating the language to reflect women-centred care and shared decision-making where appropriate. As

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				described in the section on equality considerations, this update will consider intrapartum care for all women but where the committee advise that there may be special considerations for women from at risk or vulnerable groups, these will be taken into consideration in the evidence review (including sub-group analysis if appropriate) and in the wording of the recommendations. It is not within the scope of this guideline to provide advice on promoting healthy practices postpartum, as that would not be part of intrapartum care.
Royal College of Anaesthetists	general	general	I support the proposed areas for review particularly with regard to pain relief in labour, position in 2nd stage when an epidural is used, oxytocic use and tranexamic acid.	Thank you for your comment.

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Royal College of Anaesthetists	005	002	If women in labour who are identified during labour to be at high risk are excluded this makes the document unusable as only after the event can you identify those who remain low risk in labour.	Thank you for your comment. We have amended this to state that this guideline is not applicable to women who are identified as high risk before labour.
Royal College of Anaesthetists	005	021	The majority of drugs used for pain relief and anaesthesia in obstetric patients fall outside licenced use – i.e. not the exception.	Thank you for your comment. We have amended the text to remove the word 'exceptionally'
Royal College of Anaesthetists	005	022 - 023	A number of drugs used by anaesthetists working in maternity units are used outside licensed indications (e.g. local anaesthetics) so this cannot really be described as exceptional.	Thank you for your comment. We have amended the text to remove the word 'exceptionally'
Royal College of Anaesthetists	006	008 - Choosing planned place of birth	Vulnerability to domestic violence should be a consideration especially in light of increase during pandemic.	Thank you for your comment. We recognise that there may be some differences in antenatal care and postnatal care for women who are vulnerable to domestic violence (and these are covered in the 'Pregnancy and complex social factors guideline and the Postnatal care guideline respectively)

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				but that there is likely to be less difference in Intrapartum care. However, we will consider this group separately if we identify specific questions where amendments to the recommendations are required.
Royal College of Anaesthetists	006	008 - Hygiene measures	This needs to be looked at in view of the emergence of covid-19 and the particular measures needed – the current guidance is very general and makes little mention of the risk of transmission of infection from the mother to the healthcare worker nor of the risk posed by birth partners.	Thank you for your comment. The management of pregnancy and birth in relation to Covid-19 has not been prioritised for inclusion within the scope of this update, as there is separate guidance produced by NICE and the Royal College of Obstetricians and Gynaecologists on this subject.
Royal College of Anaesthetists	006	008 - Education & early assessment	Women should be given information antenatally not just about how to 'cope with pain' but pain relief available (or not) at their planned place of birth.	Thank you for your comment. We agree that women should be given information about pain relief available in different settings of birth and will include this in the editorial

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				update planned for this section of the guideline.
Royal College of Anaesthetists	007	008 - Initial assessment of women	Section 1.4.3 Reason to transfer to an obstetric unit should include women who request epidural analgesia.	Thank you for your comment. Transfer for women who request regional analgesia is already covered in the section on information about regional analgesia (recommendations 1.9.1 and 1.9.2 in the current guideline).
Royal College of Anaesthetists	007	008 - Controlling gastric acidity	Section 1.7.5 Do not give antacids in labour to control gastric acidity as the effect only lasts for 15-30 minutes. Give for symptom control only. Whilst antacids are appropriate for symptom control of reflux and are used prior to GA, they are not appropriate for use in women who need control of gastric acidity because of their risk of needing general anaesthesia – this should H2 blockers or proton pump inhibitors although I am not sure of the current status of oral ranitidine following the SDA in December 2019.	Thank you for your comment. We will discuss with the committee and consider making an editorial change to the guideline to remove antacids and to include proton pump inhibitors as an option for the control of gastric acidity.
Royal College of Anaesthetists	007	008 - Pain relieving strategies	Evidence since 2017: May help severe back pain in 1st stage of labour for up to 120 minutes, (resource poor setting); better than saline for pain relief 1st stage up to 90 minutes; no effect on need for other analgesia.	Thank you for your comment. We are not sure which intervention you are referring to, but believe it may be water papules, which are included in the scope of this update and

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				will be the subject of an evidence review.
Royal College of Anaesthetists	007	008 - PCA opioids v IM injection	Weibel: Cochrane review 2017: Poor quality evidence: more research on safety – neonatal and maternal, required.	Thank you for your comment and for informing us of this Cochrane review, which we will consider when we carry out the evidence review for this topic
Royal College of Anaesthetists	007	008 - Inhalational analgesia	Should the environmental impact be addressed? Safety implications of use in water.	Thank you for your comment. We will be making an editorial change to the guideline to make women aware of the environmental impact of Entonox. We have not prioritised an evidence review on the safety of Entonox in a water birth as we are not aware of any evidence relating to this topic.
Royal College of Anaesthetists	007	008	Section 1.7.6 in the guideline. Refer to the danger of hyponatraemia if drinking too much water in labour. Drink isotonic drinks to thirst	Thank you for your comment. The guideline already recommends isotonic drinks and we plan to carry out an editorial update to highlight

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				the potential risk of hyponatraemia.
Royal College of Anaesthetists	008	008 - Establishing and maintaining epidural analgesia	Section 1.9.6 in the guideline. Monitor motor block and efficacy of analgesia hourly (see Association of Anaesthetists safety guideline 2019).	Thank you for your comment. The existing guideline provides recommendations on monitoring women with regional analgesia, and we note the reference you have supplied is a consensus guideline which suggests additional checks for motor blocks. We therefore plan to consider whether an editorial amendment can be made to the current monitoring recommendations by the committee.
Royal College of Anaesthetists	008	CTG conservative measures	Do not offer IV fluids if not hypotensive as excess clear fluids especially with oxytocin leads to fluid overload and hyponatraemia.	Thank you for your comment. We will be carrying out editorial revisions to update the recommendations on drinking, intravenous fluids and monitoring of urine output and fluid balance during

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				labour to reduce the risk of hyponatremia.
Royal College of Anaesthetists	009	008 - Epidural analgesia	Section 1.9.2: analyses of post 2005 studies show epidural analgesia is not associated with increased instrumental deliveries.	Thank you for your comment. We are aware of a 2018 Cochrane review which found that epidurals did increase the rate of instrumental deliveries and so do not plan to prioritise this question for inclusion in the scope as it is unlikely that the recommendations will change.
Royal College of Anaesthetists	009	008 - Pushing in 2nd stage	See comment 14	Thank you for your comment. Comment ID73 refers to use of Entonox, not pushing in the 2nd stage of labour, so I am afraid we are unable to discern what this comments relates to.
Royal College of Anaesthetists	009	008 – Women's position	Section 1.9.7 Position in labour with epidural. BUMPES study showed upright position in 2nd stage associated with statistically significant decrease in SVD compared with recumbent and non-statistically significant increase in perineal trauma.	Thank you for your comment. We will be undertaking a systematic review to identify the evidence for the optimum position in the second stage of labour, but thank you for

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				telling us about the BUMPES study
Royal College of Anaesthetists	009	008 - Obs in 1st stage section 1.12.7	Fluid balance with input/ output for all women not frequency of urine.	Thank you for your comment. We will be carrying out editorial revisions to update the recommendations on drinking, intravenous fluids and monitoring of urine output and fluid balance during labour to reduce the risk of hyponatremia.
Royal College of Anaesthetists	010	008 - PPH management	The maximum bolus dose of syntocinon IV is 5 units: [BNF] 10 unit bolus has been associated with maternal demise.	Thank you for your comment. We plan to undertake an editorial revision of this section of the guideline and to amend this dose.
Royal College of Anaesthetists	010	008 - PPH management	The maximum dose of ergometrine is 500mcg by whatever route; i.e. it cannot be repeated.	Thank you for your comment. We plan to undertake an editorial revision of this section of the guideline and to amend this dose.
Royal College of Anaesthetists	010	008 - PPH management	TXA; prophylactic/ treatment dose/ part pf PPH protocol how many doses?	Thank you for your comment. The evidence for prophylactic use of tranexamic acid is

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				lacking, although we are aware of an ongoing trial. New evidence was identified by surveillance relating to its use in treatment only and so this is the aspect of its use we will be updating.
Royal College of Anaesthetists	010	Postpartum haemorrhage - point 1.14.29 in guideline	Some acknowledgement should be made that the risk factors listed for PPH would mean that most would have been excluded from being covered by this guidance anyway as they would be classified as having a higher risk pregnancy.	Thank you for your comment. We plan to make an editorial update to this section of the guideline and will consider adding wording to this effect.
Royal College of Anaesthetists	010	Postpartum haemorrhage – point 1.14.32 in guideline	Oxytocin should only be given in a dose of 5IU as an intravenous bolus although this can be repeated but caution should be exercised due to the possibility of cardiovascular instability or collapse.	Thank you for your comment. We plan to undertake an editorial revision of this section of the guideline and to amend this dose.
Royal College of Anaesthetists	010	008 - Expediting birth 1.13.37	Record time when decision made and communicated to relevant team members (HSIB/ MBRRACE – communication failures).	Thank you for your comment. We think the existing recommendations cover informing the team and recording the time.
Royal College of Midwives	General	General	Please consider the inclusion of neuro-axial block monitoring for women with obstetric neuraxial block	Thank you for your comment. The existing guideline

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			https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/full/10.1111/anae.14993	provides recommendations on monitoring women with regional analgesia, and we note the reference you have supplied is a consensus guideline which suggests additional checks for motor blocks. We therefore plan to consider whether an editorial amendment can be made to the current monitoring recommendations by the committee.
Royal College of Midwives	002	007	Timely interventions, when interventions are necessary. This wording implies they always are.	Thank you for your comment. We have amended the wording as you suggest to clarify that interventions may not always be necessary.
Royal College of Midwives	002	026 - 003	It is not specified whether the percentage of homebirths reported (0.85%) refers only to those births taking place in NHS Establishments, given that most live births outside NHS establishments takes place at home (as reported by ONS). In which case both percentage should be reported.	Thank you for your comment. We have amended this to state that the number of home births as a percentage of total births is 2.1%, as we agree this is the most useful indicator.

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Royal College of Midwives	003	001 - 002	Not only personalised but also more equitable care. The NHS long term plan should also be cited with its aim to tackle health inequalities and improve care for all women, including those most vulnerable https://www.longtermplan.nhs.uk	Thank you for your comment. We have added the NHS Long Term Plan to the documents cited.
Royal College of Midwives	005	013 - 015	Suggested rewording: All settings where women may give birth including home, freestanding midwifery unit, alongside midwifery unit or obstetric unit.	Thank you for your comment. We have revised the order of these settings as you have suggested.
Royal College of Midwives	013	008 - 009	Should this question also consider role of virtual consultation in assessing PRoM where possible.	Thank you for your comment. We do not think a virtual consultation to assess PROM would be appropriate as a clinical examination would be necessary.
Royal College of Midwives	013	016 - 020	We especially welcome those research questions on oxytocin management given the findings of the Ockenden report.	Thank you for your comment and your support for these questions.
Royal College of Midwives	014	004 - 005	The benefits and risks of active management should include short and long-term consequences of active management.	Thank you for your comment. We will conduct a systematic review to identify the benefits and risks of active management, and will agree

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				with the committee a range of appropriate outcomes.
Royal College of Midwives	014	022 - 024	What is the preferred position for birth in women? Consider qualitative studies on women's experiences of birthing positions.	Thank you for your comment. When we develop the review protocol for this question we will discuss with the committee the type of evidence and outcomes to be included, and if appropriate will consider qualitative studies on women's experience.
Royal College of Nursing	General	General	The Royal College of Nursing (RCN) welcomes the opportunity to review and comment on the draft scope for the NICE Intrapartum care for healthy women and babies guideline. The RCN invited members who care for pregnant women and babies to review the document on its behalf. The comments below reflect the views of our members.	Thank you for sharing this scope with your members. We have addressed your individual comments.
Royal College of Nursing	001	018	The surveillance decision to update the guideline on intrapartum care for healthy women and babies was quite focused i.e. on risks associated with epidural, the woman's position in the second stage of labour, intrapartum interventions to reduce perineal trauma, risks	Thank you for your comment.

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			associated with active management, route of administration of oxytocin during active management, delayed cord clamping and management of postpartum haemorrhage. New evidence found and good to see researched effectively – all integral to this guidance.	
Royal College of Nursing	002	028	Good to see care and attention paid to the Maternity Transformation Programme (MTP) which has advanced the previous work of better births, bringing it totally up to date. Through a network of support coordinated by the MTP, the Early Adopters are now taking forward the implementation of the vision in Better Births, going further and faster, and will share the learning from their experiences. The experiences of the Early Adopters will pave the way for national roll-out of initiatives that deliver safer, more personalised care for all women and every baby, improve outcomes and reduce inequalities. Early Adopters are crucial in delivering the objectives and these early adopter sites included a good representation from Clinical Commissioning Groups (CCGs).	Thank you for your comment and for providing us with some more information on the Maternity Transformation Programme.
Royal College of Nursing	003	014	The use of information from MBRRACE-UK is most important.	Thank you for your comment.
Royal College of Nursing	003	020 - 021	This will be a comprehensive guideline for women, families and all health care practitioners to use.	Thank you for your comment.
Royal College of Nursing	004	005	A good explanation provided of the equality impact assessment for the proposed guideline.	Thank you for your comment.
Royal College of Nursing	004	011	Terms to be used are appropriate.	Thank you for your comment.

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Royal College of Nursing	011	022	The related NICE guidance illustrated was both sound and appropriate.	Thank you for your comment.
Royal College of Nursing	012	029	An interesting point to consider, whether economic considerations are relevant? Should safety be a priority!	Thank you for your comment. We agree that safety should be the priority but there may be situations where the committee is comparing a number of interventions to improve safety, and cost-effectiveness may then also be considered, as well as clinical effectiveness.
Royal College of Nursing	016	019	Following publication of the guideline it is considered that healthcare practitioners will value the updated NICE pathway flow chart. These simplistic charts a great aid for all staff.	Thank you for your comment and letting us know that these pathways are useful.
Royal College of Obstetricians and Gynaecologists	General		We note that Active management of the third stage is up for review (5.2). In view of the recent Cochrane review we also plan to update the RCOG Green-top guideline on this and are happy to liaise if that would be of help as this may prove a challenging area.	Thank you for your comment. We will be happy to liaise with the RCOG greentop guideline team, within the bounds of our permitted confidentiality rules.
Royal College of Obstetricians and Gynaecologists	General		Will this update consider intrapartum care for BAME women specifically?	Thank you for your comment. This update will consider intrapartum care for all women but where the committee

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				advise that there may be special considerations for women from a BAME background, this will be taken into consideration in the evidence review (including sub-group analysis if appropriate) and in the wording of the recommendations.
Royal College of Obstetricians and Gynaecologists	General		Suggest to not use term 'normal birth' and replace with 'unassisted vaginal birth' to align with current language used in maternity services.	Thank you for your comment. We have amended the terminology from 'normal birth' to 'unassisted vaginal birth' as you suggest.
Royal College of Obstetricians and Gynaecologists	010		Seems very relevant. Please can NICE clarify the use of the term delayed cord clamping on page 10. Is 'Optimal Cord Clamping' the preferred term from neonatology at the present and therefore is it preferable to use this term instead?	Thank you for your comment. We have amended the terminology used to 'optimal'.
Royal College of Paediatrics and Child Health		1.15.6 Initial assessment of the newborn	Please include reference to: 1. ensuring optimal positioning of the baby and airway during skin to skin and 2. appropriate supervision during skin to skin to avoid Sudden Unexpected Postnatal Collapse.	Thank you for your comment. We consider this an important issue and plan to carry out an editorial update of the recommendations on skin-to-

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		baby and mother–baby bonding (2007)	See: HSIB National Learning Report Aug 2020 Neonatal collapse alongside skin-to-skin contact: https://www.hsib.org.uk/documents/238/hsib-national-learning-report-neonatal-collapse-alongside-skin-to-skin-contact.pdf These recommendations are also included in UNICEF Baby Friendly Standards https://www.unicef.org.uk/babyfriendly/new-hsib-report-confirms-importance-of-close-monitoring-of-babies-in-immediate-postnatal-period/	skin contact to include advice on positioning and checking on the baby.
South Eastern Trust	004	026	The Trust welcome the focus on subgroups of older women ,those from BAME background or from deprived socioeconomic groups particularly as these groups continue to have higher maternal and neonatal mortality and morbidity(MBRACE-UK:Saving Lives Improving Mothers Care 2020)	Thank you for your comment.
South Eastern Trust	005	008	Groups that are not covered women who are having their labour induced. As a Trust we would like woman who are otherwise low risk who undergo a mechanical induction for postdates to be included in the guideline	Thank you for your comment. Initial care of women who are having their labour induced (by whatever method) is covered by the NICE guideline on inducing labour, but you are correct that once active labour is established, maternal

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				and fetal monitoring should be carried out as described in the Intrapartum care guideline. We have therefore amended this exclusion to clarify this. However, when searching for evidence for interventions, women who have had induction of labour will be excluded as outcomes may be different in this group of women and evidence may not be generalisable to the population of women who are not induced.
South Eastern Trust	005	028	The Trust welcomes the review of all non-regional analgesia given the increase in maternal requests for alternate coping strategies in labour	Thank you for your comment. This update will consider certain aspects of non-regional analgesia, as described in section 3.5 of the scope.
South Eastern Trust	007		The Trust welcomes the review of evidence of the use of intravenous PCA in labour verus intermittent injection as all Trusts in Northern Ireland offer Remifentanil PCA for labour analgesia	Thank you for your comment.

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South Eastern Trust	008	010	The draft scope does not intend to review the existing guideline on Measuring fetal heart rate (2017). Regionally in Northern Ireland all Trusts have adopted physiological CTG interpretation as have many units in the UK and we feel this needs to be addressed in this update of the guideline so that practice can reflect NICE Guidance	Thank you for your comment. We plan to make editorial changes to the wording of the CTG recommendations in the guideline to aid implementation, as described in the scope, and will consider the role of physiological CTG interpretation
South Eastern Trust	009		Intrapartum interventions to reduce perineal trauma (2007). The Trust welcomes the update of existing recommendations and would suggest including the Cochrane Review (2017) which concluded that the use of warm compresses may reduce the rate of third and fourth degree tears and considering RCOG advice on OASIS care bundle and Finnish grip	Thank you for your comment. We will be undertaking a systematic review to identify the evidence for interventions to reduce perineal trauma, but thank you for telling us about the Cochrane review and other existing work in this area.
South Eastern Trust	011	003	The impact of Raised BMI on place of birth will not be covered by the guideline. Given the secondary analysis of the Birthplace study on Impact of maternal BMI on intrapartum outcomes(2014) and the UKMidSS Severe Obesity Study(2018) both report better birth outcomes for parous women with a larger BMI than normal weight Primigravida we as a Trust feel this evidence should be reflected in NICEguidance	Thank you for comment. We agree that it is not clear at what BMI levels different places of birth should be advised, and we have note there is a discrepancy with the Intrapartum care guideline for

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				women at high risk, so we plan to carry out an evidence review to clarify these points.
Swansea Bay University Health Board	013	General	BMI 35 – 39.9. Guidance for place of birth for multiparous women with a previous vaginal delivery, normal additional antenatal surveillance and no other co morbidities. Although not covered in this review we feel this group would benefit from inclusion in the evidence review for this guideline. **Reference:** Rowe et al., 2018, DOI 10.1186/s12884-016-0868-1 Hollowell et al., 2014. DOI: 10.1111/1471-0528.12437	Thank you for comment. We agree that it is not clear at what BMI levels different places of birth should be advised, and we have note there is a discrepancy with the Intrapartum care guideline for women at high risk, so we plan to carry out an evidence review to clarify these points.
Swansea Bay University Health Board	029	1.8	No reference to pain-relieving benefits of one to one support by a midwife. **Reference**: Bohren et al., 2017. Cochrane Systematic Review. https://doi.org/10.1002/14651858.CD003766.pub6	Thank you for your comment. Recommendations on one-to-one support for women in established labour are already included in this guideline, therefore we do not consider that a new evidence review in this area will be necessary. The evidence review already outlines that there is evidence to suggest that women with one-to-one care throughout

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				their labour are significantly less likely to have caesarean section or instrumental vaginal birth, will be more satisfied and will have a positive experience of childbirth.
Swansea Bay University Health Board	033	1.10	Due to the known variation in CTG interpretation and practices it would be helpful to review evidence for a national standardised approach.	Thank you for your comment. We plan to make editorial changes to the wording of the CTG recommendations in the guideline, as described in the scope. We hope that this will help ensure a national standardised approach to practice and interpretation of CTG.
Swansea Bay University Health Board	057	1.12.13	Delay in 1st stage – consideration of anatomy and physiology in relation to environmental factors and oxytocin release.	Thank you for your comment. We think the current recommendation takes into account the anatomy, physiology and women's emotional state so we have not prioritised this

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				recommendation for an update.
Swansea Bay University Health Board	061	1.13.12	Consider inclusion of warm compresses to reduce incidence of perineal trauma. **Reference**: Magoga et al., 2019. DOI: 10.1016/j.ejogrb.2019.06.011 Aasheim et al., 2017. Cochrane Systematic Review DOI:10.1002/14651858.CD006672	Thank you for your comment. We will be undertaking a systematic review to identify the evidence for interventions to reduce perineal trauma, but thank you for telling us about the Cochrane review and other existing work in this area.
TensCare Limited	007	008	**Pain relief (2014) No evidence review: retain recommendations from existing guideline** Existing guideline for TENS pain relief was carried over from 2007 CG55 guideline. This was based on a 2005 review (Carroll et al. 2005. Transcutaneous electrical nerve stimulation in labour pain: a systematic review) A 2009 Cochrane review which looked at similar data up to 2008 (Dowswell T, Bedwell C, Lavender T, Neilson JP, Transcutaneous electrical nerve stimulation (TENS) for pain relief in labour (Review)) concluded "Although it is not clear that it reduces pain, women should have the choice of using TENS in labour if they think it will be helpful."	Thank you for your comment. We have not prioritised a review of the evidence for TENS as part of this update, as we do not think there is any evidence that is likely to change the recommendations. However, we recognise that some women may choose to obtain and use TENS, particularly in early labour, and the current recommendation wording may suggest this should not be

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			Despite this conclusion current NICE guidance is that TENS should NOT be offered. In 2011 a review paper discovered that there had been serious methodology problems with the majority of TENS research papers up to that date – the most important of which was that TENS is dose-related and that reliable placebo controls are therefore difficult to establish. (Bennett, Hughes & Johnson 2011. Methodological quality in randomised controlled trials of transcutaneous electric nerve stimulation for pain: Low fidelity may explain negative findings. PAIN 152 (2011) 1226–1232) Since 2011, at least 39 papers have been published on TENS for perinatal pain relief, using the Bennett et al recommendations. Conclusions of all have shown positive benefits. Evidence for TENS has not been reviewed since 2005. There is a substantial body of new evidence that should be reviewed..	condoned. We therefore plan to make an editorial change to the guideline to clarify this.
The Pelvic Partnership	General	General	We welcome the opportunity to provide comment on this draft guideline scope of the Intrapartum care for healthy women and babies guideline, to ensure the most responsive and considerate maternity care provided. The ongoing focus on assessing the women's experience of labour and birth in making this analysis is particularly welcome.	Thank you for your comment.
The Pelvic Partnership	013	021 - 025	We welcome further guidance on labouring positions for women in the second stage of labour, with and without an epidural in situ.	Thank you for your comment and support for this question.

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			For many women with pregnancy-related pelvic girdle pain (PGP), it is important to encourage positions where the woman can comfortably move her legs apart without causing severe pain. This can have a significant impact on their pain during labour, and on their recovery from PGP postnatally. We find that positions that work better for women with PGP include kneeling or on all fours, standing or leaning forward or lying on her side with the top leg supported. We consider these positions should also be continued even if fetal monitoring is taking place. Water births are also recommended for women with PGP; as well as the relief from pain, labouring and birthing in water allows the woman to maintain control over her legs and reduce the chances of aggravating her PGP. We consider that the lithotomy position should be particularly avoided as much as possible for women with PGP, to avoid extra strain on their pelvis. When the woman has an epidural, it is even more important to suggest labour and birthing positions that offer support and don't risk exacerbating the woman's PGP, because she will have no control over her movements and therefore what positions her body is moved	When reviewing the evidence and making recommendations we will consider if it will be possible to tailor recommendations to take into account women with pelvic girdle pain or other similar problems.

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			into. At this point, the woman with PGP may be at risk of severe pelvic dysfunction if her PGP is not taken into consideration.	
University Hospital Southampton NHS Foundation Trust	-	-	Consideration of range of terminology and whether likelihood of any confusion: NICE uses women at low-risk of complications NMC standards now say 'universal' and 'additional care' https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf OOA describe 'enhanced care' https://www.rcoa.ac.uk/sites/default/files/documents/2020-06/EMC-Guidelines2018.pdf	Thank you for your comment. We appreciate you informing us of the terminology used by these other documents, but note that these refer to competencies for midwives and care of the critically ill woman during childbirth, respectively. We do not therefore think there should be confusion with the NICE terminology which makes clear the population to which the guideline is applicable.
University Hospital Southampton NHS Foundation Trust	016	008 Choosing planned place of birth	There is new evidence to consider since 2014 guideline – Reitsma 2020 https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30063-8/fulltext Recommendation 1.1.8 pg. 15/108 update required re: supervision of midwives – no doubt you have identified this already	Thank you for your comment. We have reviewed this new evidence and consider it only partially applicable to the UK population and unlikely to change existing recommendations on place of birth, so we have not

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				prioritised this for inclusion in the scope of this update. We had already noted that as part of the editorial changes the terminology supervisor of midwives' should be changed.
University Hospital Southampton NHS Foundation Trust	016	008 Medical conditions that may affect planned place of birth	Some indications within the tables around indications for birth in OLU could be reviewed e.g. **Table 6 (medical conditions indicating increased risk suggesting planned birth at an obstetric unit)** need review. Some may indicate the need for possible neonatal involvement post-birth e.g. HIV low viral load, hyperthyroidism, gestational diabetes diet controlled, normal scans etc. but the place of birth could be an alongside midwifery led unit with MDT planning/guidelines in place as required and this may reflect current practice. GBS - some units offer IAP in MLU. **e.g. Table 7 (other factors indicating increased risk suggesting planned birth at OLU)** induction of labour in absence of oxytocin infusion – current practice for some units to support ongoing care in MLU if prostaglandin only or ARM providing maternal and fetal observations normal.	Thank you for your comment. Some of the factors you refer to (such as HIV) would put women into a high-risk category and so the recommendations on place of birth would indicate that they should be advised to give birth in an obstetric unit. We are however, planning to carry out editorial changes to the recommendations on planning place of birth, to ensure they are consistent with current practice (for example, siting of intravenous lines and administration of intravenous

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			To update including UKMidSS re: BMI >35 and good outcomes of multiparous women with BMI 35-39.9 Rowe et al 2018 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0208041 Concern that all the tables may overshadow the recommendation for continuous risk assessment of women at low risk of complications.	antibiotics by midwives), and use of outpatient induction with dinoprostone. We agree that it is not clear at what BMI levels different places of birth should be advised, and we have note there is a discrepancy with the Intrapartum care guideline for women at high risk, so we plan to carry out an evidence review to clarify these points. We plan to carry out an editorial amendment to emphasise the ongoing risk assessment that is necessary, even for women who present initially at low risk.

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University Hospital Southampton NHS Foundation Trust	016	008 Communication/Women's experience	Consideration of other gender identities and use of 'women' throughout NICE guidance	Thank you for your comment. The scope already contains the explanatory text: 'For simplicity of language, this guideline will use the term 'woman' or 'mother' throughout, and this should be taken to include people who do not identify as women but who are pregnant.' A similar explanation will be included in the guideline.
University Hospital Southampton NHS Foundation Trust	016	008 Measuring fetal heart rate as part of initial assessment (1.4.9)	Review evidence for current recommendation for CTG monitoring for high head in nulliparous woman/ suspected macrosomia. Transfer of care to OLU may be appropriate but is CTG indicated? Could there be some clarification of the recommendation re: initial assessment and transfer of women with PROM >24 hours as this sometimes causes confusion and leads to transfer of women *already* in established labour as soon as ROM exceeds 24 hour point (recommendation 1.4.3). Maybe section 1.11 on pre-labour ROM needs to move up a bit?	Thank you for our comment. Any transfer of care to an obstetric unit usually requires a CTG on arrival, so we have not prioritised this for an evidence review in the scope. The initial assessment of women who present with PROM is included as one of the review questions in the scope, and as part of this

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				update we will consider if the recommendations need to be reordered.
University Hospital Southampton NHS Foundation Trust	016	008 Ongoing assessmen t	In absence of new evidence, Committee to consider evidence available and wider data e.g. MBRRACE and offer consensus on ongoing assessment in latent phase. Evidence suggests that we sometimes fail to recognise changes of stage of labour and need to increase frequency of monitoring. Furthermore, consider lay member views and experiences of prolonged latent phase and strengthen recommendations around analgesia, individualising care and support. 1.14.29 Need to strengthen recommendations on *ongoing* risk assessment for PPH in labour.	Thank you for your comment. We plan to carry out an editorial update to clarify the need for ongoing assessment in the latent phase. The recommendations for early assessment in the latent phase already include offering individualised support and analgesia so we have not prioritised this as part of this update. We plan to carry out an editorial update to the section of the guideline on assessing risk factors for PPH, and will include details on the ongoing nature of this assessment.
University Hospital Southampton NHS Foundation Trust	016	008 General principles	Include advice of how to safely transfer the baby either by car seat or by flat neonatal pod.	Thank you for your comment. Transfer of the mother and baby would be carried out by

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		for transfer of care	Advice needed to ensure some consistency around things to consider when making decision re: transferring mother and baby together or separately. Resuscitation Council offers clear guidance on NLS/resuscitation of babies but there is need for clearer guidance on safe transfer of babies who are perhaps not transitioning well and may require some level of respiratory support.	the ambulance service and details of the equipment used and support required would be determined by their protocols, and so are not within the scope of this guideline.
University Hospital Southampton NHS Foundation Trust	016	008 Care and observations for women with regional analgesia	Review BUMPES study data Brocklehurst 2017 https://www.bmj.com/content/359/bmj.j4471	Thank you for your comment, and for alerting us to this paper which considers outcomes from different birthing positions. We will be undertaking a systematic review to identify the evidence for this review question but it is very helpful that you have identified this reference.
University Hospital Southampton NHS Foundation Trust	016	008 Measuring fetal heart rate (2017)	1.10.3 1.10.10 and 1.10.16 Please define rise in baseline rate- evidence suggests baseline variation of up to 20 bpm but greater than this may signify concerns- or include in baseline rate	Thank you for your comment. We plan to make editorial changes to the wording of the CTG recommendations in the guideline to aid implementation, as described in the scope, and will consider

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				a clearer definition of the rise in baseline rate.
University Hospital Southampton NHS Foundation Trust	016	008 Second stage	Strengthen recommendations around second stage as we sometimes fail to recognise signs second stage or there is sometimes evidence of 'trial pushing' with no specific time frame in mind e.g. see Each Baby Counts 2019 https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/each-baby-counts-2019-progress-report.pdf Consensus statement would be helpful to ensure consistency of frequency of intermittent auscultation in passive second stage. National variation here. More explicit guidance around bladder care to avoid distension/retention.	Thank you for your comment. We plan to carry out an editorial update to the definitions for the duration of the second stage and the definition of delay. The frequency of intermittent auscultation is already included in the guideline (recommendation 1.13.2). We plan to make editorial changes to the recommendations on monitoring fluid balance and urine output which may include bladder care.

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University Hospital Southampton NHS Foundation Trust	016	008 Epidural and second stage	1.9.9 - Review evidence regarding waiting an hour for descent following confirmation of full dilatation Yee et al 2016 https://pubmed.ncbi.nlm.nih.gov/27741203/	Thank you for your comment. We plan to carry out an editorial update to the definitions for the duration of the second stage and the definition of delay, and will be carrying out an evidence review on the benefits and risks of immediate or delayed pushing.
University Hospital Southampton NHS Foundation Trust	016	008 Oxytocin in the second stage (2007)	update recommendations on dosage and titration of oxytocin- as per first stage scope plans	Thank you for your comment. We are not aware of any new evidence which would allow an evidence-based update of these recommendations but we will consider if editorial revision of these recommendations could reduce confusion amongst staff.
University Hospital Southampton NHS Foundation Trust	016	008 Initial assessmen t of the	Expand and consider evidence on how to assess babies that are not white Caucasian where possible- some over reliance on APGAR	Thank you for your comment. We are aware that other NICE guidelines have suggested alternative methods of

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		newborn baby and mother–baby bonding (2007)		defining appearance for non-white babies and will update this recommendation in line with these other NICE guidelines.
University Hospital Southampton NHS Foundation Trust	016	008 Perineal care	Please can you provide some guidance on guidance in light of OASI care bundle, particularly in regard to recommendations made around routine examination of anal sphincter.	Thank you for your comment. We will be conducting an evidence review to identify the effectiveness of perineal care, but are aware the OASI care bundle contains a wider range of interventions. We will not be including these in the evidence review as information, episiotomy technique and perineal/anal sphincter examination are already covered by the recommendations in the guideline.
University of Central Lancashire	General	General	While the tone of the current guidelines is generally woman centred, there are still statements such as 'Transfer the woman…'. Even if there are other sections of the text that make it clear that directive	Thank you for your comment. As part of the update of this guideline we will be updating

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			actions such as this cannot be done without the womans consent, there are other sections that imply that such consent should always be 'obtained' after an action is recommended, implying that it is a bit of an afterthought (for example, under the statement 'when conducting a vaginal examination…' the issue of consent is raised – so sequentially after the event itself). There are published papers showing that some staff have reported organisational pressure to ensure they 'get consent' whatever the woman says, to make sure she falls in with what the 'guideline' says. To ensure that staff have permission to properly and authentically enable women to decline such interventions if that is their choice, actions such as these could be framed in a less directive fashion throughout the guideline. Indeed, 'obtaining' consent is in itself directive: it would better (in line with Montgomery and Lanarkshire) to frame such decisions as being the result of mutual discussion with the woman based on what is 'material' to her, with a strong statement that her decision must be genuinely respected by the individual practitioner and the organisation they are working in, whatever that decision is. In many places in the current guideline uses the term 'offer', which is helpful, but this is not consistent throughout the guideline. We feel that assessment of consistency in this matter throughout the new version of the guideline should be addressed in the final scoping document	the language to reflect women-centred care and shared decision-making where appropriate. However, where a recommendation is for an action to be taken by healthcare professionals, it may be phrased using an action verb, and it is NICE style to use the term 'offer' (for a recommendation where there is good evidence that that is the preferred course of action) or 'consider' (for recommendations where the evidence base is not as strong).

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University of Central Lancashire	Definition of labour onset	Definition of labour onset (and specifically 1.12.6 of the current guidelines)	Based on new evidence, both ACOG and the WHO have changed the definition of active labour onset. It is very important that this is reconsidered for updating in this guideline, otherwise practice in the UK in this area will not be based on the current evidence in this area. Globally, WHO is now replacing the partogram cited in 1.12.6 with their new, tested, Labour Care Guide to reflect the new evidence.	Thank you for your comment. We are aware that there have been some changes to the definitions of the latent and active stages first stage of labour and are planning to undertake an editorial review of the definitions included in the current guideline.
University of Central Lancashire	Review of antibiotics for assisted vaginal birth	In scoping document	The recent trial of prophylactic antibiotics for assisted vaginal birth raises a number of questions. The outcome measure was antibiotic prescriptions provided for women (and there was no laboratory evidence on actual infection). 100% of the intervention group had antibiotics, and a further 10% had an additional antibiotic prescription – in the control group, 20% overall had an antibiotic prescription. In terms of secondary outcomes, while there was evidence of less perineal pain and breakdown in the intervention group, which is important, hospitalisation (for severe infection, presumably?) and quality of life scores did not differ between the groups. The long term impact of antibiotics via breastmilk on the emerging neonatal immune system is unknown. Many neonates already receive antibiotics postnatally for raised maternal temperature in labour, so this could be their second exposure in the first day or two of life, when the neonatal immune system/fetal gut is making critical	Thank you for your comment. It is useful to have these suggestions on these longer term and baby outcomes to consider when we review the use of antibiotics for assisted vaginal birth. NICE recommendations are usually framed in terms of 'offer' or 'consider' to incorporate maternal choice and consent, and we will review the potential benefits and harms of antibiotics.

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			adjustments that are biologically designed to protect it against long term disease risk. Exposing many women and babies to antibiotics at this stage to protect against minor infections, with no impact on QoL, has very serious potential implications for antibiotic resistance in the longer term, and to the risk that serious infections might, in the near future, not be treatable. If the evidence on prophylactic antibiotics is considered, please do this in the light of the potential longer term effects, on the basis of the precautionary principle - if we get to a point where this in-principle risk is actually evident, it will be too late. We would urge that any recommendation based on this trial is framed as an offer to women, and that they should be fully informed of the risks and benefits. Antibiotics should not be given routinely without consent.	
University of Central Lancashire	Attitudes to pain and pain relief in childbirth (2007)	In scoping document	A recent and extensive qualitative systematic review on women's experiences of pain relief including their experience with care providers (Thomson et al 2019) should be included into this review of the evidence.	Thank you for your comment. We will be reviewing several aspects of pain relief as part of this update and when developing the review protocols will agree with the committee the type of evidence and outcomes that would provide the best evidence for decision-making.

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University of Central Lancashire	Womens experiences as a key outcome measure	Water birth (2007) as one example	We feel that womens experiences, as a key outcome measure for the guideline, are not properly weighted in some of the decisions made about which areas to address in the current scoping document, given new evidence in some areas about what matters to women and on womens views and experiences. For example, there is new evidence on womens views and experiences of water birth (eg Feeley et al 2021; not from trials, but we understand that NICE takes account of a range of types of evidence?), and on the basis of this (and in the absence of evidence of harm in the latest Cochrane review of this area (Cluett 2018), and given the widespread use of waterbirth), there appears to be evidence to recommend, based on the guideline 'womens experiences' outcome. This may possibly be true of other aspects of the guideline. We wonder why aspects of the guideline where womens experiences may change the recommendation do not appear to be under consideration?	Thank you for your comment. The surveillance process identifies topics which need updating based on new evidence which is likely to lead to a change in the recommendations, and although there may be new evidence on women's experiences this may not always mean that the recommendations need amending and so would not always trigger an update to a topic. We agree that women's experiences are a key outcome measures and when developing the review protocols will agree with the committee the type of evidence and outcomes that would provide the best evidence for decision-making.

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University of Central Lancashire	Definition of labour progress	Definition of labour progress (and specifically 1.12.6 of the current guidelines)	Based on new evidence, both ACOG and the WHO have changed the parameters for physiological labour progress. It is very important that this is reconsidered for updating in this guideline, otherwise practice in the UK in this area will not be based on the current evidence in this area. Globally, WHO is now replacing the partogram cited in 1.12.6 with their new, tested, Labour Care Guide to reflect the new evidence.	Thank you for your comment. We are aware that there have been some changes to the definitions of the latent and active stages first stage of labour and are planning to undertake an editorial review of the definitions included in the current guideline.
University of Central Lancashire	Choosing planned place of birth (2014) No evidence review: retain recommendations from existing guideline	In scoping document	Based on the two largest systematic review/meta-analyses regarding the safety of homebirths (500,000 planned homebirths), particularly in well integrated systems such as the UK, it seems an omission to not review place of birth and recommendations. (Reitsma et al, 2020 / Hutton et al, 2019)	Thank you for your comment. We have reviewed this new evidence and consider it only partially applicable to the UK population and unlikely to change existing recommendations on place of birth, so we have not prioritised this for inclusion in the scope of this update.
University of Central Lancashire	034 - 053	All	This is a comment on the current guideline, for consideration in the scoping document.	Thank you for your comment. This guideline covers the population of women who are

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			Continuous CTG should only be used when an abnormality is suspected or detected. By definition, therefore, using it moves a woman/fetus from a category of 'healthy' to one of higher risk. We don't really understand, therefore, why there are nearly 20 pages of text on the use, interpretation and etc of CTG/fetal blood sampling, and other related techniques in a guideline designed for healthy women and babies. Surely this should be a separate document that is referred to if suspected or actual pathologies arise that require CTG monitoring? Otherwise, logically, other tests and interventions for a whole range of other kinds of abnormalities that might arise in a labour that starts of as uncomplicated should also be included, which would move the guideline from being about women with healthy pregnancies to being one about all women in labour? We can see the logic for having a section about when to offer/advise use EFM, and when a women who has had EFM might be advised that it is safe for her to move back to intermittent monitoring (assuming she has agreed to monitoring) – but surely the detailed techniques of monitoring should be a separate guideline?	low risk at the start of labour, but all women need to be monitored and the intensity of that monitoring will increase if their risk profile increases during labour. There may be an argument for having a separate CTG guideline but a summary of the CTG recommendations are available as a separate document on the NICE web-page resources tab.

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