Intrapartum care for healthy women and babies (update)

Consultation on draft guideline - Stakeholder comments table
25/04/23 – 06/06/23

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Association for Improvements in the Maternity Services	Guideline	005	016	Rec 1.1.2 and 1.1.3 We understand that these sections are not being revised but we ask you to consider adding a section on the information to be given to multiparous women antenatally, as their experience of labour, especially the latent first stage, may be very different to that of nulliparous women.	Thank you for your comment. The committee agreed that this antenatal information about labour should be given to all women and so removed the word 'nulliparous' so information will also be provided to multiparous women.
Association for Improvements in the Maternity Services	Guideline	005	016	Rec 1.1.3 We are pleased to see the recommendations to discuss and record care choices during pregnancy. We note that the recently updated Induction Guideline had a more detailed section on 'Information and Decision-making' and feel it would be beneficial to include an equivalent in this guideline i.e., including the need to give information about the benefits and risks of all the options, encourage women to look at other information, discuss it with others and ask questions, and to "Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given."	Thank you for your comment. New recommendations on communication have been included in the guideline, and there are a large number of discussion and decision points in the guideline and each of these emphasises the need to discuss risks and benefits and support the woman's choice. In addition an over-arching recommendation about supported decision-making has been added to the guideline in the section on care in all settings.
Association for Improvements in the	Guideline	006	001 - 002	Rec 1.1.3 We feel that women should not be put under pressure to decide about their care until they are ready to do so, so would suggest adding the words "but they do not	Thank you for your comment. The wording of this recommendation has been revised to emphasise that women can make decisions, and change their mind, at any time.

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Maternity Services				have to make a decision in advance if they prefer to wait and see how their pregnancy and labour progress."	
Association for Improvements in the Maternity Services	Guideline	006	014 - 015	Rec 1.2.2 We suggest making this "Audit *and publish* transfer times…" as this is information which should be freely available.	Thank you for your comment. This change has been made.
Association for Improvements in the Maternity Services	Guideline	009	008 - 011	Rec 1.3.6 We note that although data from the study by Hollowell, J., Pillas, D., Rowe, R. et al. (2014) BJOG 2 121(3): 343-55 is used in Evidence review A, their conclusion that "Nulliparous low risk women of normal weight had higher absolute risks and were more likely to require obstetric intervention or care than otherwise healthy multiparous women with BMI > 35 kg/m(2) (maternal composite outcome: 53% versus 21%). The perinatal composite outcome exhibited a similar pattern" is not discussed. The implication of their finding is that healthy multiparous women with a high BMI are at lower risk than nulliparous women of 'normal weight, and this is echoed by the RCOG recommendation to offer birth in an MLU to multiparous obese women with no other risk factors ((see Care of Women with Obesity in Pregnancy (Green-top Guideline No. 72)) We think this is very	Thank you for your comment. In response to stakeholder feedback we have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have also included this information in the expanded recommendation.

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				important information and would like to see a comment included that for healthy multiparous women the risks appear to be lower than for nulliparous women with a BMI in the 'healthy' range.	
Association for Improvements in the Maternity Services	Guideline	018		Table 12 We found the new comment "Risk factors associated with group B streptococcus where it is likely that antibiotics in labour will be needed" unclear, as we would have expected antibiotics to be offered to anyone who had tested positive for GBS. It would be helpful to explain what the 'Risk factors' might be.	Thank you for your comment. The wording of this line in Table 12 (now Table 8) has been simplified to state that it relates to the situation where intrapartum antibiotics are required for group B streptococcus.
Association for Improvements in the Maternity Services	Guideline	019	004 - 007	Rec 1.3.10 We are puzzled that this mentions a senior or consultant midwife but only a consultant obstetrician, as this task is often undertaken by other senior members of staff. We suggest this is reworded to say "A consultant or senior obstetrician or midwife."	Thank you for your comment. This has been amended to clarify that it can be a senior or consultant obstetrician as you suggest.
Association for Improvements in the Maternity Services	Guideline	021	011	Rec 1.4.7 To properly support informed decision-making we suggest adding to the list in section 1.4.7 "provide information on the absolute risks and benefits of care options or suggested interventions in an easily understood format, and encourage the woman to ask questions or for further information if she wishes."	Thank you for your comment. There are numerous places in the guideline where supported decisions need to be made so an over-arching recommendation has been added to the beginning of the section on care throughout labour settings to state these general principles about discussing risks and benefits and the opportunity to ask questions. The recommendations on communication

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					already cover the type and format of information.
Association for Improvements in the Maternity Services	Guideline	021	015 - 027	Rec 1.4.9 We are delighted to see these expectations about the style of care to be given.	Thank you for your comment.
Association for Improvements in the Maternity Services	Guideline	022	002	As some women have more than one birth companion who should all be welcomed this should use the plural or say "birth companion**(s)**"	Thank you for your comment. This has been changed to the plural 'companions' in line with other recommendations that mention birth companions.
Association for Improvements in the Maternity Services	Guideline	022	012 - 014	Rec 1.4.10 Whilst we are glad to see this recommendation to provide information about pain relief options we suggest the wording "enquire if the woman would like to discuss her pain relief options…"to reflect the fact that not all will wish to do so.	Thank you for your comment. The committee agreed that, as you suggest, in many cases women had already made choices about pain relief options before labour which would have been recorded in their birth plan, and did not want to have to repeat the whole discussion when they met their midwife at the beginning of labour. The recommendation is therefore already written to establish if the woman had already made decisions or if she needed information to make a decision. It has not therefore been reworded as you suggest.
Association for Improvements in the	Guideline	022	012 - 014	Rec 1.4.10 We would also like to add "Do not attempt to initiate further discussion of these options when the woman has made clear her	Thank you for your comment. The committee agreed that, as you suggest, in many cases women had already made choices about pain relief options before labour which would have

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Maternity Services				preference." as this may be distressing for women.	been recorded in their birth plan, and did not want to have to repeat the whole discussion when they met their midwife at the beginning of labour. The recommendation is therefore already written to establish if the woman had already made decisions or if she needed information to make a decision. It has not therefore been reworded as you suggest.
Association for Improvements in the Maternity Services	Guideline	028	004 - 020	Rec 1.6.21 & Table 14 We are surprised that PCA remifentanil is only compared with pethidine and not with epidural, especially when the recommendation frames it as an option for women who do not want an epidural. We think there should be similar information and a table comparing PCA remifentanil with epidurals, with particular focus on the evidence for mode of birth, so that women can make an informed choice between these options.	Thank you for your comment. The protocol for this review only considered the comparison of remifentanil with opioids as the committee agreed that it was this comparison that best reflected its place in therapy, and that it was not intended to be replacement for epidurals which offer local anaesthesia and pain relief. The advice that remifentanil should be considered as an option for women who do not want an epidural has been removed from the recommendation.
Association for Improvements in the Maternity Services	Guideline	028	020	Table 14 We think there is a typo in the comparison for Spontaneous Vaginal Birth. Under remifentanil it says the figure is for SVB per 1000 but under IM pethidine it says it's for births with forceps or ventouse per 1000.	Thank you for your comment. This typo has been corrected.
Association for Improvements in the	Guideline	032	010 - 013	Rec 1.6.30 We question the need for a midwife to tell someone whether they are capable of standing up and what additional	Thank you for your comment. The committee did not agree with your comment and advised that it was safer for a midwife trained in caring

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Maternity Services				qualifications or training would be required for a midwife to formally assess someone's muscle strength. We suggest changing this to "Advise women with an epidural in situ that if they *feel confident that they* have sufficient leg strength and sensation they can *choose to* mobilise, *but may need* assistance *or support*, and their legs may feel heavier than usual."	for women with epidurals to assess leg strength and sensation before a woman tried to mobilise.
Association for Improvements in the Maternity Services	Guideline	034	028	Rec 1.7.2 We are concerned to see the directive recommendation that all women with suspected rupture of membranes after 37+0 weeks but no risk factors should be seen in person within 6 hours when evidence review B states that there is no evidence to support the need for review at this stage. While some women may find it reassuring to be seen in person, pressure to attend within a certain time limit may be disruptive to the progress of labour and the woman's emotional well-being. Also, we do not agree with the committee's belief that a 6-hour limit is sufficient to allow a woman to spend the night at home. We suggest that the non-evidence based requirement for an in-person review within 6 hours is removed, and replaced with "offer the woman a review within 6 hours if she wishes."	Thank you for your comment. The committee agreed that 6 hours may be too short a time period and have amended to 'within 12 hours'.

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Association for Improvements in the Maternity Services	Guideline	034 - 035	023	Rec 1.7.2 We are puzzled that there are no recommendations for what should happen at the in-person review, (other than in 1.7.4 to perform a speculum exam if needed to confirm breaking of the waters), and no mention of the need to inform women about what to expert at the review. We suggest adding a recommendation that the woman should be informed of what will happen at the review, and the benefits, risks and potential consequences of having one, so that she can make an informed decision about whether to accept the offer.	Thank you for your comment. The review when a woman attends following prelabour rupture of the membranes would be the same as the initial assessment of a woman in labour, so a cross-reference has been added to the section of the guideline that describes this initial assessment.
Association for Improvements in the Maternity Services	Guideline	035	001 - 002	Rec 1.7.2 We are pleased to see the confirmation that the review could take place at home, but would like to see this strengthened to say "Offer women the choice of having the review at her home, in a midwifery-led unit, or an assessment centre at an obstetric unit."	Thank you for your comment. The recommendation has been changed to 'offer…' as you suggest.
Association for Improvements in the Maternity Services	Guideline	042	013 - 015	Rec 1.8.17 We welcome the additional clarification, however, as women do not need anyone's permission to drink it would be better to word this as "Inform the woman that it's fine to drink during labour whenever she is thirsty but there is no benefit to drinking more than normal."	Thank you for your comment. The recommendation has been amended to state that the woman can drink when she is thirsty.

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Association for Improvements in the Maternity Services	Guideline	048	010	Rec 1.8.45 This should more properly say "she can *decide whether and when* to start, stop or restart the oxytocin" to reflect the woman's legal right to make decisions about her care.	Thank you for your comment. This recommendation has been amended to state the woman's choice about oxytocin will be supported.
Association for Improvements in the Maternity Services	Guideline	049	0011	Rec 1.8.45 We would like to see the following point added: "explain the reasons why it might be necessary to stop the oxytocin and what the options would be in that case"	Thank you for your comment. This recommendation has been amended to state that hyperstimulation may lead to the oxytocin being stopped. Later recommendations already discuss the possibility of restarting oxytocin so this has not been repeated here
Association for Improvements in the Maternity Services	Guideline	049	012 - 013	Rec 1.8.45 We appreciate this section is not being reviewed but want to question the comment that oxytocin "will not influence the mode of birth or **other outcomes**" given that you have added the information that "oxytocin can cause hyperstimulation which may increase the chance of fetal hypoxia." We suggest that these lines be clarified to say "...will not influence the mode of birth but may cause hyperstimulation which can affect fetal wellbeing."	Thank you for your comment. The committee identified from the evidence used to create these recommendations in 2007 that the 'other outcomes' referred to neonatal outcomes and so clarified the recommendation to state that. As the risk of hyperstimulation is already described in another bullet point it was not repeated here.
Association for Improvements in the Maternity Services	Guideline	049	014 - 016	Rec 1.8.45 As continuous monitoring should not be used without consent this should more properly say "that its use will mean that *she is recommended to have* her contractions and her baby monitored continuously using cardiotocography"	Thank you for your comment. This recommendation lists factors related to the use of oxytocin to discuss with women, so the wording has not been amended in this context, but women always have the right to decline any intervention.

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Association for Improvements in the Maternity Services	Guideline	049	014 - 016	Rec 1.8.45 We also suggest clarifying that it's "her baby*'s heartbeat*" that would be monitored as this may not be obvious to all women.	Thank you for your comment. The recommendation has been amended to clarify that it is the baby's heartbeat.
Association for Improvements in the Maternity Services	Guideline	049	018 - 019	Rec 1.8.45 We think it would be helpful to include the explanation of hyperstimulation and it's potential consequences which is given in the guideline Inducing Labour: "– this is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise." It should also recommend explaining what the options would be if hyperstimulation occurs, including how common it would be to have an unplanned caesarean as a result.	Thank you for your comment. A definition of hyperstimulation has been included in the 'terms used' section of the guideline, and hyperlinked from the recommendations. The definition used in the NICE guideline on inducing labour was used to ensure consistency between guidelines. The options if hyperstimulation occurs are already included in the last bullet of this recommendation, but the committee had not reviewed evidence on the risk of unplanned caesarean and so were not able to add this detail.
Association for Improvements in the Maternity Services	Guideline	049	025 - 027	Rec 1.8.48 We welcome this guidance on the need to limit the frequency of increments but are concerned that there is no guidance on the size of increments that should be used. Without this there is still a risk that excessive ramping up of the dose could occur. Please add some guidance about the size as well as the frequency of increments that would be appropriate.	Thank you for your comment. The precise details of how the dose should be increased are in the Summary of Product Characteristics for oxytocin so are not repeated in the guideline.
Association for Improvements	Guideline	050	001	Rec 1.8.49 We welcome the reminder to "use oxytocin in labour with caution"	Thank you for your comment.

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Association for Improvements in the Maternity Services	Guideline	051	007 - 012	Rec 1.8.51 This does not mention what options could be considered in case the CTG remains pathological or the woman does not consent to it being restarted. We suggest including a recommendation for this.	Thank you for your comment. If the CTG is pathological then the actions to be taken are covered in the NICE guideline on fetal monitoring in labour which is hyperlinked from the recommendation above. If the woman does not consent to oxytocin being restarted then ongoing management of the delayed first stage would continue.
Association for Improvements in the Maternity Services	Guideline	052	008 - 009	Rec 1.9.7 We think that the comment "pushing while exhaling may shorten the active second stage of labour for multiparous women" is misleading. The comparison in the evidence review was between directed pushing while exhaling and directed pushing with breath-holding, so it would be clearer to say "if directed rather than spontaneous pushing is used then pushing while exhaling may shorten the active second stage of labour compared with pushing while breath-holding (Valsava manoeuvre) for multiparous women"	Thank you for your comment. The recommendation has been amended to clarify that if directed pushing is used it should be while exhaling.
Association for Improvements in the	Guideline	057	026 - 029	Rec 1.9.33 We welcome this guidance on the need to limit the frequency of increments but are concerned that there is no guidance on the size of increments that should be used.	Thank you for your comment. The precise details of how the dose should be increased are in the Summary of Product Characteristics

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Maternity Services				Without this there is still a risk that excessive ramping up of the dose could occur. Please add some guidance about the size as well as the frequency of increments that would be appropriate	for oxytocin so are not repeated in the guideline.
Association for Improvements in the Maternity Services	Guideline	061	001 - 014	Rec 1.10.6 and Rec 1.10.7 We are aware that the Cochrane review Active versus expectant management for women in the third stage of labour - Begley, CM - 2019 | Cochrane Library concluded that "In women at low risk of excessive bleeding, it is uncertain whether there was a difference between active and expectant management for severe PPH or maternal Hb less than 9 g/dL (at 24 to 72 hours)" Whilst we are pleased to see the absolute risks quoted we feel that there needs to be clarification that these figures are for all women regardless of their individual risk status, and that for women at low risk there may be no difference between active and physiological management,	Thank you for your comment. The recommendation relates to all women and so it is not necessary to specify this. The committee reviewed the evidence for active versus physiological management in all women, not broken down by risk level, so are not able to make separate recommendations for low risk or high risk women.
Association for Improvements in the Maternity Services	Guideline	061	001 - 014	Rec 1.10.6 and Rec 1.10.7 We feel that it would be clearer to present the data as a comparison table as was done for the comparison of remifentanil and pethidine in Table 14 e.g. that with active management about 13 per 1,000 women would be	Thank you for your comment. This information has been turned into a table as you suggest.

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				expected to experience a haemorrhage of more than 1 litre (so 987 would not) etc.	
Bigbirthas	Guideline	General	General	Overall, we think this guideline is much improved from a plus-size perspective. More individualised, fewer arbitrary BMI cut-offs, more about providing info about risks in order to make informed decisions and then supporting women and birthing people in those choices.	Thank you for your comment.
Bigbirthas	Guideline	008	017	Rec 1.3.5 - Welcome recommendation of data provision on birth pool 'availability'. But this must reflect reality. Hoping NICE will be clearer and more specific in its recommendations here. Yes, a unit may HAVE a birth pool, but if everyone who requests access to it is denied, it's meaningless to claim one is available. Midwives are reporting pools in obstetric units are often dusty and used for storage because no one is ever allowed in them. For data provision on birth pool availability to be useful, we need to know how many people requested pool use in the past year, and crucially, how many of them actually got to use one. We hear repeatedly of people choosing a unit because there's a pool – only on the day they are in labour to be refused access due to	Thank you for your comment. This recommendation has not been amended as the use of birthing pools was not included as part of this update. However, updating the recommendations on use of birthing pools has already been prioritised by NICE when the ongoing POOL study has published and your comments will be considered as part of this update. Please see: https://www.nice.org.uk/guidance/cg190/resources/2023-exceptional-surveillance-of-intrapartum-care-for-healthy-women-and-babies-nice-guideline-cg190-11443418173/chapter/Surveillance-decision?tab=evidence#planning-place-of-birth

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				staffing/training/equipment/concerns re BMI/ other aspects of health/care – e.g. having consented to a medication / form of fetal monitoring that is incompatible with immersion in water (so not truly informed consent if not warned of the impact on later choices/aspects of their birth plan). Finding out *in labour* the birth pool is not an option is not good enough. Women are reporting that this impacts their trust in care providers in subsequent pregnancies, potentially forcing them to elect for a home birth they don't necessarily want in order to access their chosen form of evidence-based pain relief that was previously advertised and then denied.	
Bigbirthas	Guideline	010 011	002 & 005 003	We really approve of how data is being presented in this draft guideline. Using standardised 'natural frequency' per 1,000 AND the reverse (i.e. saying how many pregnancies this does not happen in) is really clear and helpful in giving perspective. Thank you also for including the difference per 1000 pregnancies - as it is easy to forget that people in the lower risk categories also experience these outcomes! This is so important to help people to understand the data provided, and hopefully displaying the data in this way will also reduce the tendency	Thank you for your comment and support of how these tables are presented.

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				for some healthcare professionals sensationalise risks which are in reality only marginally higher for 'high risk' groups.	
British Maternal & Fetal Medicine Society	Evidence review G	General	General	Although the introduction states that the review questions are "what is the most effective position for birth…", the protocol then only compares women assuming an upright position with any recumbent position. This restriction from "what is the most effective position" to "upright compared with recumbent" is perhaps why the conclusions of the evidence review are so flawed. Recumbent positions includes lying flat on ones back, which is associated with veno-caval compression and fetal compromise, and also include being lateral (lying on ones side) which does not present any risk to the fetus. To conflate both of these positions into the comparison group is inappropriate and will certainly not allow a review to find the most "effective position".	Thank you for your comment. The committee decided during the formulation of the review protocol that all positions of birth should be considered in our evidence review. However only 2 studies were identified for review (BUMPES 2017 and Golara 2022) and they have been analysed separately (not pooled) as the positions of birth were defined/classified differently in these studies. BUMPES 2017 included left or right lateral positions in recumbent group specifically excluding lying flat on ones back. The smaller study of Golara 2002 came from a major UK maternity unit with around a 50-year history of research on this specific topic and although not mentioned in this publication the committee considered it inconceivable that the recumbent position would include lying flat on the back. Furthermore, this study only studied the passive not active second stage. Accordingly, the committee did not consider that in their review of the evidence they included women lying flat on their back in the comparison recumbent group. The committee's discussion and interpretation of the evidence is detailed in

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					section 'The committee's discussion of the evidence' of the evidence review.
British Maternal & Fetal Medicine Society	Evidence review G	General	General	The reviews introduction also causes some concern that the group were not in equipoise when reviewing the available evidence. The statement that "the assistance of gravity associated with upright positions is also thought to lead to benefits during labour and birth" is not referenced – and this is because there is no evidence, either clinical, or physiological, so support this statement. It is a widely held assumption, but which is almost certainly incorrect. However, if this is the view held by members of the guideline group before reviewing the evidence it is perhaps not surprising that they maintained this belief even when presented with clear evidence to the contrary.	Thank you for your comment. This sentence has been removed from the introduction section of the evidence review.
British Maternal & Fetal Medicine Society	Evidence review G	General	General	In summary, for women with an epidural in site, one very large and well conducted trial has shown, with high probability, that assuming the lateral position in the second stage of labour leads to an increased change of a spontaneous vaginal birth. This evidence should be provided to women so that they can make their own choices about which position to choose. However, suggesting, as the consultation document does, that any	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We have conducted separate analysis for BUMPES 2017 and Golara 2002 as the studies had different definitions/classifications of positions of birth. BUMPES 2017 included left or right lateral positions in recumbent group and Golara 2002 had spending as much time

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				position in these women is reasonable is disingenuous and ignores the existing evidence.	as possible in bed or in a chair during the passive phase in recumbent group]. There was statistically significant increase in spontaneous vaginal births for nulliparous women who were in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour. The committee's discussion and interpretation of the evidence is detailed in section 'The committee's discussion of the evidence' of the evidence review.
British Maternal & Fetal Medicine Society	Evidence review G	006	015 - 016	Another fallacy perpetuated in line 15-16 of the introduction is that in women without an epidural "all positions are more likely to be possible" – and while this may be true for	Thank you for your comment. This comment is included as part of the introduction of the review chapter providing some background information, not as a means of rationalising the

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				being mobile, it is certainly not true when it comes to adherence to any allocated position in a clinical trial. Women with an epidural, who should be completely pain free, are more likely to be able to maintain each allocated position, whereas women without an epidural are more likely to move and become non-adherent.	evidence. The committee reviewed the evidence on positions of birth separately for women with and without an epidural. The committee's discussion of evidence including non-adherence to interventions in women without an epidural is detailed in the 'The committee's discussion of the evidence' section.
British Maternal & Fetal Medicine Society	Evidence review G	013	006 - 008	In the BUMPES trial there was clear evidence of a highly statistically significant 6% absolute difference in the chances of having a spontaneous vaginal birth. This cannot be considered to be "no evidence of an important difference". Given that the intervention, lying on ones side, is completely risk free and of no cost to either women or the health service, we believe this conclusion is wrong. It is hard to understand how the committee judged the trial to be of low quality. Again, we believe this is incorrect. The trial, the single largest trial of maternal position in labour ever conducted, was rigorous in its design and execution. It was peer reviewed prior to funding by the NIHR HTA Programme. It was overseen by an independent Trial Steering Committee and Data Monitoring Committee, and the reports were peer reviewed by the	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We have conducted separate analysis for BUMPES 2017 and Golara 2002. There was statistically significant increase in spontaneous vaginal births for nulliparous women who were in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their

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				BMJ prior to publication, the NIHR HTA Programme prior to the final report being published, and it was then further per reviewed in order to be awarded the BMJ UK Research Paper of the Year in 2018. It is extremely improbable that all these peer reviewers were wrong and the guideline review group have found substantial flaws which would compromise the validity of the findings where no one else has.	knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour. The committee's discussion and interpretation of the evidence is detailed in section 'The committee's discussion of the evidence' of the evidence review. This guideline review uses the GRADE approach for assessing quality of evidence as detailed in the NICE guidelines manual and the methods chapter for this review. Each study is assessed for risk of bias. As participants and personnel could not be blinded to intervention allocation in BUMPES 2017, subjective outcomes were downgraded for risk of bias. The quality of each outcome is assessed following GRADE processes taking into account risk of bias of the individual studies, the inconsistency, imprecision and indirectness.
British Maternal & Fetal Medicine Society	Evidence review G	016	036 - 042	There were specific criticisms in the consultation document which suggest that the BUMPES trial report (both the BMJ paper and the NIHR report) were not read in any detail. The review group stated that the evidence from BUMPES was at risk of bias. They justified this by describing that a proportion of women had their labours	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We have conducted separate analysis for BUMPES 2017 and Golara 2002. There was statistically significant increase in spontaneous vaginal births for nulliparous women who were

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				induced. And they claimed that the primary outcome of the trial was not adjusted for this hence the results "were downgraded for indirectness". This is false. The research group acknowledged that labour induction may be a confounder and clearly stated the following in the BMJ paper: "We further adjusted the analysis of the primary outcome to investigate the impact of known prognostic factors (age, ethnicity, diagnosis of delay, onset of labour—induced versus spontaneous)", and the results section states: " A clear statistically significant difference (at the 5% level) in the incidence of the primary outcome of spontaneous vaginal birth was found between the groups, with 35.2% (548/1556) of women achieving spontaneous vaginal birth in the upright group compared with 41.1% (632/1537) in the lying down group (adjusted risk ratio 0.86, 95% confidence interval 0.78 to 0.94) (table 3). This represents a 5.9% absolute increase in the chance of spontaneous vaginal birth in the lying down group (number needed to treat 17, 95% confidence interval 11 to 40). This result was unchanged when adjusting for age, ethnicity, diagnosis of delay, and the nature of the onset of labour (adjusted risk ratio 0.86, 95% confidence interval 0.79 to	in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour. The committee's discussion and interpretation of the evidence is detailed in section 'The committee's discussion of the evidence' of the evidence review. Thank you for highlighting that BUMPES 2017 was downgraded for indirectness. This has been amended and not downgraded for indirectness in the evidence report and the quality rating has been changed accordingly. This guideline review uses the GRADE approach for assessing quality of evidence as detailed in the NICE guidelines manual and the

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				0.94)." This barely detectable difference between the two analyses demonstrates that labour induction is not a confounder of the relationship between the positions that were compared in the BUMPES trial.	methods chapter for this review. Each study is assessed for risk of bias. As participants and personnel could not be blinded to intervention allocation in BUMPES 2017, subjective outcomes were downgraded for risk of bias. The quality of each outcome is assessed following GRADE processes taking into account risk of bias of the individual studies, the inconsistency, imprecision and indirectness.
British Maternal & Fetal Medicine Society	Evidence review G	017	021 - 030	The group also states that the "actual adopted positions for birth in the two groups were not reported". Again, this is false. This was reported, albeit briefly, in the BMJ paper, but was reported extensively in the HTA report (which was found by the reviews search), suggesting that the report, which contains these additional data, was not read. On line23-28 on page 17 of the consultation document suggests that there was scepticism about what was defined as recumbent. We suggest the group read the HTA for the detail they believed was not available to them.	Thank you for your comment. We have now noted the actual positions of birth in BUMPES 2017 in our evidence report. We have also amended relevant sections in 'The committee's discussion of the evidence' to reflect this.
British Maternal & Fetal Medicine Society	Evidence review G	017	038 040	A general point in this section on page 17 of the consultation document is that the phrase "in their experience" appears in relation to the committees deliberation. However, when	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We

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				there is high quality and clear evidence that the lying down position is association with an important and meaningful difference to women in labour, this phrase has no place in such a document.	have conducted separate analysis for BUMPES 2017 and Golara 2002. There was statistically significant increase in spontaneous vaginal births for nulliparous women who were in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour.
British Maternal & Fetal Medicine Society	Guideline	028	001	1.6.20 Are there not implications of proposing opioid use for home birth if there is no means to monitor the patient's vital signs and most notably their respiratory rate/oxygen saturation or will these be assessed? Also if morphine is available should naloxone not also be available?	Thank you for your comment. This recommendation has been changed to remove the details regarding intramuscular opioids being used in home births, as this is covered in an earlier recommendation (1.6.17) The committee were aware that some centres do have procedures in place for midwives to

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					administer opioids, which include protocols for monitoring and use of naloxone.
British Maternal & Fetal Medicine Society	Guideline	035	017	1.7.6 do these options also apply if there is evidence of GBS colonisation? I see this is noted later but would be useful to clarify that this section should be referred to otherwise there is the impression IOL may be deferred in all cases	Thank you for your comment. The recommendations subsequent to 1.7.6 (1.7.7 to 1.7.10) all relate to care of a woman who does not have group B streptococcus, where there are more options and choices for women, and then the care of women who are group B streptococcus positive is addressed separately, so the committee agreed it was not necessary to state in 1.7.6 that these recommendations relate to women without group B streptococcus.
British Maternal & Fetal Medicine Society	Guidance	050	001	1.9 Are there any recommendations regarding monitoring of u&e in prolonged labour/first stage?	Thank you for your comment. The committee were not aware of any particular criteria or reason to carry out monitoring of urea and electrolytes in prolonged labour and so did not add this to the recommendations.
BSUG	Guideline	Rec 1.16.5		All women should have a rectal examination performed as part of routine postpartum care to avoid missing a button hole rectal tear.	Thank you for your comment. The recommendation on perineal care after birth has been amended to state that all women should have a rectal examination as you suggest.
Caesarean Birth	Guideline	001	Box (General)	Re: The guideline helps women to make an informed choice about where to have their baby and about their care in labour. It also aims to reduce variation in aspects of care.And: It focuses on women who give birth	Thank you for your comment. The committee have amended the text in the title and in this introductory section of the guideline to remove the terminology 'healthy women' as this may be perceived to be a value judgement on

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				between 37 and 42 weeks of pregnancy ('term'). And: p.1 Who is it for? …Healthy women who have had a straightforward pregnancy and give birth between 37 and 42 weeks of pregnancy. There are some women who are undecided about their birth plan choices, and who may want to discuss all mode and place of birth options during their antenatal care. If NICE is producing this guideline specifically for women who are already certain they want to plan a vaginal birth, and avoid an emergency caesarean birth, then it is important to state this explicitly from the outset. This is also important for reducing variations in antenatal care.Suggested change (in one example): Healthy women who have had a straightforward pregnancy and **plan to have a vaginal** birth between 37 and 42 weeks of pregnancy Or: Healthy women who have had a straightforward pregnancy and **are planning to have a vaginal** birth between 37 and 42 weeks of pregnancy	people's health status. However, the committee did not agree to limit the guideline to women who have planned to have a vaginal birth: there may be women who planned to have a caesarean birth who end up having a vaginal birth, and so the guideline is applicable to them as well.
Caesarean Birth	Guideline	001	Box (General)	Throughout this intrapartum care guideline, caesarean birth is presented in the context of an adverse outcome that women planning a vaginal birth want to avoid; for example, 'complication' (p.17), 'increased chance' (p.31) 'reduced caesarean birth' (p.87,90),	Thank you for your comment. For women who wish to have a vaginal birth then a caesarean birth will be seen as a risk or complication, and many women will want to avoid the invasive nature of the procedure, the post-operative recovery required, and the impact on future

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				'risk' (p.65), 'risk factors that make a caesarean birth more likely' (p.131), 'the risk of a caesarean birth' (p.132). Could NICE please consider ensuring that the type of caesarean birth is made clear throughout this guideline, using one or more of the following words to prefix caesarean birth: **emergency, intrapartum, urgent, unplanned** NICE notes the importance of accurate birth mode terminology when communicating with women, on page 102. The risks associated with an emergency caesarean birth are greater than those of a planned caesarean birth, and it would be helpful to support greater clarity and consistency across all NICE guidance if this distinction was made. This would also be in line with how different types of vaginal birth are described (i.e. spontaneous vaginal birth, birth with forceps or ventouse).	pregnancies. The committee chose to define caesarean birth as 'planned' or 'unplanned' (as emergency has other connotations relating to timing and safety) and so added 'planned' or 'unplanned' into the recommendations where it was necessary to improve clarity.
Caesarean Birth	Guideline	005	004	1.1.1 Re: Give all nulliparous women information antenatally about: Please consider revising (to include plan for vaginal birth: Give all nulliparous women planning a vaginal birth antenatal information about: Ideally, all women should receive information about the different modes and places of birth that are	Thank you for your comment. Women may use the information on planning place of birth to also consider or reconsider their planned mode of birth so this recommendation has been left more general and not restricted to women who are only planning a vaginal birth. However, it has been amended so it is now applicable to all women and not just nulliparous women.

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				supported in the NHS, but in the context of this guideline, the information is very specific to women who have decided to plan a vaginal birth, and not 'all' women. At a minimum, removal of the word 'all' would be appreciated.	
Caesarean Birth	Guideline	005	016	1.1.3 Re: For all women, discuss their preferences and choices for care during labour and birth as early as possible in their pregnancy, and record these choices. This is an example of why it is problematic for this guideline to be published entirely separately from NICE guidance on caesarean birth. The guidance is titled, "Intrapartum care", but increasingly contains guidance related to antenatal care, during which all mode of birth discussions should be discussed, together with place of birth. Notably, NICE does not produce separate guidelines for different places of birth ("home, freestanding midwifery unit, alongside midwifery unit or obstetric unit"), and the same principles apply in the context of providing women with all the information they need during antenatal care discussions to make a fully informed decision (also see note #9 re: p.96-97). The recommendation itself (to move discussions earlier in pregnancy and better support informed	Thank you for your comment. The committee agree that there is some synergy between the information on planning mode of birth at the beginning of the caesarean birth guideline and planning place of birth at the beginning of the intrapartum care guideline. To help address this the committee have added a link at the beginning of this guideline to advise that it should be read in conjunction with the caesarean birth guideline. The committee have also passed this information to the NICE surveillance team to consider if, in future updates, planning place and mode of birth would be better considered in the same guideline. Women may use the information on planning place of birth to also consider or reconsider their planned mode of birth so this recommendation has been left more general and not restricted to women who are only planning a vaginal birth.

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				consent and decision making in an emergency) is excellent, thank you. However, again, it would be helpful to remove 'all', and/or specify that this is for women who are choosing to plan a vaginal birth: For [all] women planning a vaginal birth, discuss their preferences and choices for care during labour and birth as early as possible in their pregnancy, and record these choices.	
Caesarean Birth	Guideline	006	003 - 004	Re: they are free to change their mind at any time, including during labour or while giving birth In these recommendations on antenatal education, does NICE mean to include women who may request a caesarean birth at these stages? And women who may belatedly decide they would like an epidural? Certainly, there are numerous reported litigation claims providing evidence that women are not always be free to change their mind, but even with negligence aside, it is important that NICE offers clear and realistic guidance to women. For example, women need to know it is possible that an anaesthetist may not be available at short notice if they change their mind about having an epidural, or an obstetric theatre may not be available if they request a caesarean. Especially in hospitals with experience of staffing shortages and/or surgery delays (as	Thank you for your comment. The guideline provides recommendations to advise on the best possible clinical care. There may be situations where operational aspects need to be taken into consideration when implementing these recommendations in individual cases but the committee agreed it was not within the remit of the guideline to provide advice on operational issues.

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				is sometimes highlighted in CQC inspection reports), women should be informed about this as it may affect their decision making. Essentially, in practice, women are not always free to change their mind "at any time". Suggest rewording or adding more information and/or caveats to make this clearer.	
Caesarean Birth	Guideline	006	005 - 006	Re: choices and decisions may need to be discussed again if problems or changes occur during pregnancy or labour. By 'changes' here, does NICE also refer to changes in the woman's preferences and/or decision making?	Thank you for your comment. Yes, this recommendation applies to any changes, but the right of the woman to change her mind has been emphasised in the bullet point above this one.
Caesarean Birth	Guideline	086	016 - 017	Re: The evidence showed that use of sterile injected water did not increase the risk of caesarean birth Please amend this so that it specifies an unplanned caesarean birth: The evidence showed that use of sterile injected water did not increase the risk of **emergency [or intrapartum]** caesarean birth	Thank you for your comment. The committee chose to define caesarean birth as 'planned' or 'unplanned' (as emergency has other connotations relating to timing and safety) and so added 'unplanned' into the rationale.
Caesarean Birth	Guideline	096		Re: This guideline covers the care of healthy women who go into labour at term (37+0 to 18 41+6 weeks). About 700,000 women give birth in England and Wales each year, of whom about 40% are having their first baby. Most of these women are healthy and have a straightforward pregnancy. Almost 90% of	Thank you for your comment. The context section of the guideline is only intended to be a brief introduction to the topic covered by the guideline. However, some additional detail has been added, including the proportion of women who had a spontaneous vaginal delivery, those who had birth with forceps and ventouse, and

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				women will give birth to a single baby after 37 weeks of pregnancy, with the baby presenting head first. About two thirds of women go into labour spontaneously. In this series of facts, could NICE also include the number of women who have a spontaneous vaginal birth, and forceps or ventouse – both as a percentage of all 700,000 women giving birth, and as a percentage of the (40%) nulliparous mothers. Re: Since the original guideline was published in 2014, the number of women giving birth in England and Wales each year has risen, the rate of intervention (births with forceps or ventouse and caesarean birth) has increased slightly,… This does not provide very specific information related to numbers and percentages for nulliparous and multiparous pregnancies. It also distinguishes the different types of assisted vaginal birth (forceps and ventouse) but expresses 'caesarean birth' as being only one type. Again, clarification of the types of caesarean births NICE is referring to is really important for clarity, communication and understanding. My organisation is aware of numerous examples where emergency caesarean birth outcomes are presented in antenatal education as being a risk with 'all' caesarean	those who had a caesarean. We have not been able to locate this data broken down by nulliparous or multiparous women or by type of caesarean birth so have not added that detail.

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				births. Ensuring consistently clear use of birth mode language and definitions will help improve this issue.	
Caesarean Birth	Guideline	096 097	028 – 030 001	Re: It is important that the woman is given information and advice about all available settings when she is deciding where to have her baby, so that she is able to make a fully informed decision. This includes information about outcomes for the different settings. This is an example of why the guideline needs to include a statement of intent that it is for women who are planning a vaginal birth, and **not 'all' women**.	Thank you for your comment. The committee did not agree to limit the guideline to women who have planned to have a vaginal birth: there may be women who planned to have a caesarean birth who end up having a vaginal birth, and so the guideline is applicable to them as well.
Caesarean Birth	Guideline	097	011 - 012	Re: The guideline is intended to cover the care of healthy women with uncomplicated pregnancies entering labour at low risk of developing intrapartum complications. Please add: 'healthy women who are planning a vaginal birth'	Thank you for your comment. The committee have amended the text in the title and in this context section of the guideline to remove the terminology 'healthy women' as this may be perceived to be a value judgement on people's health status. However, the committee did not agree to limit the guideline to women who have planned to have a vaginal birth: there may be women who planned to have a caesarean birth who end up having a vaginal birth, and so the guideline is applicable to them as well.
Caesarean Birth	Guideline	098	021	1.1.3 Re: For all women, discuss their preferences and choices for care during labour and birth as early as possible in their pregnancy, and	Thank you for your comment.

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				record these choices. The rationale here is excellent, and this is a very helpful addition to the guideline for women who are planning a vaginal birth. Thank you	
Caesarean Birth	Guideline	099	021	1.3.2 Re: Advise women that additional resources to help them plan their place of birth are available on the NICE website and the NHS website. If this guideline is not edited to make clear it is only for women who want to plan a vaginal birth and avoid a[/any] caesarean birth, please include an equivalent statement for mode of birth (linking to Caesarean Birth NG192, and RCOG's Considering a caesarean birth patient leaflet). Thank you	Thank you for your comment. The guides are designed for women having a vaginal birth but may be of interest and use to women planning a caesarean birth too, as they may provide information that could impact on their decision to choose a caesarean birth, so we have not limited the audience of these resources to women planning a vaginal birth only.
Caesarean Birth	Guideline	103 & 104	Table	Re: caesarean section Please change to caesarean birth	Thank you for your comment. This table explains the changes from the previous recommendations. The use of the terminology 'caesarean section' was in the previous recommendations, that have now been amended to use the terminology 'caesarean birth'.
Caesarean Birth	Guideline	112 - 113	Table	1.4.9 Re: Support the woman so she: …maintains control of what is happening to her,… Can NICE specify that 'control' here is in the context of controlling what is happening to the woman externally (i.e. actions by health	Thank you for your comment. This recommendation has been amended to clarify that the woman should be supported to make decisions about her care (but not that she can 'control' her labour).

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				professionals – what is 'being done' to/with her) as opposed to what is happening as a consequence of the birth itself. Since the latter is not possible to control, it is unclear how this recommendation can be fully implemented.	
Caesarean Birth	Guideline	134	Table	Re: It is not associated with a longer first stage of labour or an increased chance of a caesarean birth Please indicate caesarean birth type (e.g. emergency)	Thank you for your comment. The committee chose to define caesarean birth as 'planned' or 'unplanned' (as emergency has other connotations relating to timing and safety) and so added 'unplanned' into this recommendation.
Caesarean Birth	Guideline	135	Table	As above. Please indicate caesarean birth type (e.g. emergency)	Thank you for your comment. The committee chose to define caesarean birth as 'planned' or 'unplanned' (as emergency has other connotations relating to timing and safety) and so added 'unplanned' into this recommendation.
Caesarean Birth	Guideline	135	Table	1.6.25 Re: If, after a discussion of the benefits and risks, a woman in labour chooses for regional analgesia, support her decision. This includes women in severe pain in the latent first stage of labour. [2007, amended 2023] Please remove the word 'severe' here. This recommendation should include any woman, in any level of pain, who chooses regional analgesia. Also please delete the word 'for'.	Thank you for your comment. This recommendation has been amended to remove any requirement to have 'severe pain' in order to receive an epidural.

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Caesarean Birth	Guideline	145	table	1.8.52 Re: if cervical dilatation has increased by less than 2 cm after 4 hours of oxytocin, further obstetric review is needed to assess the need for caesarean birth Please change to 'an emergency [or urgent] caesarean birth' Consider changing 'to assess the need for caesarean birth' to: 'to assess whether a caesarean birth is advisable/recommended' This would be more consistent with the language used in this text on p.100, for example: 1.8.29 Be aware that meconium is more common after full term, but should still trigger a full risk assessment and discussion with the woman about the option of transfer to obstetric-led care. [2023]	Thank you for your comment. The wording of this recommendation has been changed to 'assess whether a caesarean birth is advisable' as you suggest. The committee did not think it was necessary to state that this was an unplanned caesarean birth as it is clear this is the case from the context, and it might not be an emergency if there were no other concerns about the woman or baby.
Caesarean Birth	Guideline	153		Re: 1.9.30 If there is delay in the second stage of labour (see the expected duration of the second stage at 1.9.26 to 1.9.29), or if the woman is excessively distressed, provide support and sensitive encouragement, and assess the woman's need for analgesia/anaesthesia. [2007, amended 2023] Please change the word '**need**' above. It reads as though someone else will assess whether the woman 'needs' pain relief (or not – with pain relief denied in some cases), when it should be the woman's decision whether she wants or needs it.	Thank you for your comment. The wording of this recommendation has been changed to a more woman-centred wording, asking the woman if she needs analgesia.

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Caesarean Birth	Guideline	155	1.9.44	Re: 1.13.33 Advise the woman to have a caesarean section if vaginal birth is not possible[6].Please change to caesarean birth	Thank you for your comment. This table explains the changes from the previous recommendations. The use of the terminology 'caesarean section' was in the previous recommendations, that have now been amended to use the terminology 'caesarean birth'.
Caesarean Birth	Guideline	177		1.12.23 Re: ensure that difficult trauma is repaired by an experienced practitioner in theatre under regional or general anaesthesia Can NICE be more specific here about what 'difficult trauma' is? For example, does NICE mean 3rd and 4th degree tearing? Similarly, can NICE provide information on who 'experienced practitioner' refers to? Re: give the woman information about the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic floor exercises. [2007, amended 2023] Please change to: the importance of education/learning about pelvic floor exercises There is a danger that doing pelvic floor exercises without professional advice/education/guidance, particularly very soon after birth, can actually cause an overly tight pelvic floor, with knots of tight, painful muscle fibers causing pain.	Thank you for your comment. The wording of this recommendation has been amended to state that the appropriate place and anaesthesia for a repair should be based on the clinician's judgement as you are correct, there is no clear definition of 'difficult' trauma. The recommendation about information for the woman has also been amended to clarify that pelvic floor exercises should be taught.

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Cambridge University Hospitals NHS Foundation Trust	Guideline	009	008	Rec 1.3.6 – The evidence presented and summarised suggests there is no significant increase in risk for women and birthing people with BMI 25 – 29.9. (As per evidence review A which suggests no significant difference in adverse outcomes for BMI up to 29.9.) A large proportion of our population would be affected by this recommendation and the subsequent tables do not support the discussions advised as all but table 5 have no data. See also later comment no. re table 5. We would prefer to see this statement with more qualification of the advice. Therefore recommend changing to BMI 30 or more and adding an additional statement: Women and birthing people with a BMI of 25 – 29.9 who are planning a birth in an obstetric unit have an increased risk of caesarean section. We would also like to see better clarification of the overall risk for multips with no other medical history who have an overall lower risk of poor outcomes than low-risk nulliparous women and birthing people of normal BMI – reference Hollowell et al., 2013.	Thank you for your comment. In response to stakeholder feedback the committee agreed that that although risks seem to increase with an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this. We have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail.
Cambridge University Hospitals NHS Foundation Trust	Guideline	010	001	Table 2 - We are concerned that the composite outcome of 'stillbirth, neonatal death or the baby from needing neonatal care' will make counselling of risk challenging. It does not support informed	Thank you for your comment. We have used composite endpoints when studies reported them, but we did not combine individual endpoints if they were differences in our analysis. We specified in the protocol that we

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				decision making as neonatal admission and death are not comparable outcomes. Of note, Rowe et al., 2018 found no statistical difference in neonatal admission but this is lost in the composite representation that is used.	would include 'neonatal admission' as an outcome if reported individually or as a combined measure to capture as much information as possible. Where there was data available for individual analysis of neonatal admission, then that outcome was not combined with other neonatal endpoints. With regard to Rowe 2018, we have reported neonatal admission as an individual endpoint and not as a composite endpoint. Please see table 10 in the evidence report for the analysis of the data provided by Rowe 2018.
Cambridge University Hospitals NHS Foundation Trust	Guideline	010	004	Table 3 – To support informed consent rate of spontaneous vaginal birth separated by nullip and multip would be beneficial. Additionally, presenting this data by place of birth – i.e. rate of spontaneous birth by CLU and rate of spontaneous birth by MLU. Recommend tables are added to show chances of spontaneous vaginal birth in each setting based on BMI. Also need a table for multiparous women and birthing people only.	Thank you for your comment. In response to stakeholder feedback we have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The recommendation, the rationale and the committee's discussion of the

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					evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them.
Cambridge University Hospitals NHS Foundation Trust	Guideline	011	001	Table 4 – We are concerned that the composite outcome of 'stillbirth, neonatal death or the baby from needing neonatal care' will make counselling of risk challenging. It does not support informed decision making as neonatal admission and death are not comparable outcomes. Of note, Rowe et al., 2018 found no statistical difference in neonatal admission but this is lost in the composite representation that is used. Can rate of PPH be shown for multips as per table 3 for nullips.	Thank you for your comment. We have used composite endpoints when studies reported them, but we did not combine individual endpoints if they were difference in our analysis. We specified in the protocol that we would include 'neonatal admission' as an outcome if reported individually or as a combined measure to capture as much information as possible. Where there was data available for individual analysis of neonatal admission, then that outcome was not combined with other neonatal endpoints. With regard to Rowe 2018, we have reported neonatal admission as an individual endpoint and not as a composite endpoint. Please see table 10 in the evidence report for the analysis of the data provided by Rowe 2018. The rate of PPH for women with planned birth in an alongside midwifery unit has now been included for nulliparous and multiparous women as you suggest.

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Cambridge University Hospitals NHS Foundation Trust	Guideline	012	001	Table 5 – We feel this further confuses informed decision making as it does not break down for nullip / multip. If included it needs to show caesarean rate by planned place of birth to support women and birthing people in decision making regarding choice of place of birth.	Thank you for your comment. This table was created from evidence of women of mixed parity so it is not possible to separate for nulliparous and multiparous women. However, other tables do show data broken down by parity where it was available. As the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The recommendation, the rationale and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them.
Cambridge University Hospitals NHS Foundation Trust	Guideline	018	003	Unclear what is meant by "Risk factors associated with group B streptococcus where it is likely that antibiotics in labour will be needed"? Is this suggesting that prophylactic antibiotics can't be given in MLU/home birth settings?	Thank you for your comment. The wording of this line in Table 12 (now Table 8) has been simplified to state that it relates to the situation where intrapartum antibiotics are required for group B streptococcus. The table states that 'individual assessment is needed' and in localities where these antibiotics can be given in midwife-led units and at home births, these

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					may therefore be viable options for women to consider as their planned place of birth.
Cambridge University Hospitals NHS Foundation Trust	Guideline	021	003	The NICE shared decision making guideline excludes under 18s and there is no reference to Gillick or Fraser guidelines. Recommend that here it instead refers to ensuring that information is given to support "the woman to make informed decisions regarding her care with the support of her healthcare team".	Thank you for your comment. Decision-making in those under 18, including determination of competence, is covered in the NICE guideline on Babies, children and young people's experience of healthcare (NG204) so is not repeated in this guideline. There is also advice on pregnancy in those under 20 in the NICE guideline on Pregnancy and complex social factors (NG110). This recommendation has, as you suggest, been amended to refer to supported decisions rather than shared decisions.
Cambridge University Hospitals NHS Foundation Trust	Guideline	021	017	We request that more detail is added here to ensure informed consent is supported. It would be beneficial if it explicitly stated that the woman or birthing person has the risks and benefits explained to them, offered alternatives if there are any, is given time to ask questions and to consider their options before making a decision.	Thank you for your comment. There are numerous places in the guideline where supported decisions need to be made so an over-arching recommendation has been added to the beginning of the section on care throughout labour to state these general principles about discussing risks and benefits, the opportunity to ask questions, and obtaining consent.
Cambridge University Hospitals NHS Foundation Trust	Guideline	028	003	We are concerned that this is not sufficient evidence regarding safe use of opioids in the homebirth setting. In practice it is also challenging to provide this due to controlled drug status and primary vs secondary	Thank you for your comment. This recommendation has been changed to remove the details regarding intramuscular opioids being used in home births, as this is covered in an earlier recommendation (1.6.17) The

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				provision of the prescription for opioids. GP practices in our catchment are no longer willing to provide prescriptions to women requesting home birth which was the usual avenue for home birth medications.	committee were aware that some centres do have procedures in place for midwives to administer opioids.
Cambridge University Hospitals NHS Foundation Trust	Guideline	051	023	There is further moderate strength evidence to include recommendation of birthing as decreasing labour pain in first stage and a correlation with peanut balls reducing length of labour and increasing spontaneous birth in women and birthing people with an epidural. There is no evidence of possible harm caused by use of birthing balls. Grenvik, J.M., Coleman, L.A., Berghella, V., 2023. Birthing balls to decrease labor pain and peanut balls to decrease length of labor: what is the evidence? *American Journal of Obstetrics and Gynecology* 228, S1270–S1273. https://doi.org/10.1016/j.ajog.2023.02.014	Thank you for your comment. The committee did not look at evidence for birthing balls or peanut balls as part of this update and so were not able to make recommendations on these topics, but will pass this information to the NICE team for surveillance for consideration in a future update.
Cambridge University Hospitals NHS Foundation Trust	Guideline	067	009	Table 16 – the advice in this table is not practical in an emergency situation as it is too proscriptive and doesn't account for when PPH is not immediate.	Thank you for your comment. The advice allows for a choice of options in a number of scenarios and the committee were aware from their own knowledge and experience that there may be confusion about the order of drugs to be given, so did not agree that it was proscriptive. If PPH is not immediate then a wider choice of drugs would be available as

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					the drugs administered in the third stage of labour would no longer be relevant.
Cambridge University Hospitals NHS Foundation Trust	Guideline	080	014	Rec 1.9.15 – there is evidence that demonstrates benefits of antenatal education and manual perineal protection (MPP) for reducing severe perineal tears and we feel inclusion of this information would aid decision-making for women and birthing people. Gurol-Urganci et al (2021) demonstrated a 20% reduction in the case-mix-adjusted risk of severe perineal injury after introduction of the OASI care bundle (P=0.03), with no effect on caesarean birth or episiotomy rate. Evaluation of the bundle showed that it was acceptable and feasible for clinicians and women. Refer to: Gurol-Urganci I, Bidwell P, Sevdalis N, Silverton L, Novis V, Freeman R, Hellyer A, van der Meulen J, Thakar R. Impact of a quality improvement project to reduce the rate of obstetric anal sphincter injury: a multicentre study with a stepped-wedge design. *BJOG*. 2021 Feb;128(3):584-592. doi: 10.1111/1471-0528.16396. Epub 2020 Aug 9.	Thank you for your comment. The committee were aware of the evidence showing benefits from the OASI care bundle, but still agreed that it was not clear which of the 4 components of the bundle led to a reduction in perineal injury, and agreed that more research on the use of hand positions would be beneficial.
Chelsea & Westminster NHS	Guideline	General	General	It is disappointing not to see the use of additive language for those who do not identify as a woman, but positive that the words woman/women are now in use.	Thank you for your comment. The new NICE style guide provides advice on additive language to be more inclusive, but this

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Foundation Trust					language is not currently being applied retrospectively to all existing guidance.
Chelsea & Westminster NHS Foundation Trust	Guideline	006	003	We agree that women are free to change their mind but would suggest that their expectations for change are managed as their options may be limited depending on activity of labour ward and stage of labour.	Thank you for your comment. The guideline provides recommendations to advise on the best possible clinical care. There may be situations where operational aspects need to be taken into consideration when implementing these recommendations in individual cases but the committee agreed it was not within the remit of the guideline to provide advice on operational issues.
Chelsea & Westminster NHS Foundation Trust	Guideline	006	009	This recommendation will be challenging in practice due to the number of freestanding midwifery units available.	Thank you for your comment. The guideline provides recommendations to advise on the best possible clinical care, and this should include the option of birth in a freestanding midwifery unit for women who wish to have this. There may be situations where operational aspects need to be taken into consideration when implementing these recommendations in individual cases but the committee agreed it was not within the remit of the guideline to provide advice on operational issues, and that other options such as partnering with adjacent freestanding units may need to be considered locally.
Chelsea & Westminster NHS	Guideline	009	008 - 011	We do not agree with this statement of a BMI of 25kg/m at booking being associated with increased risks for women and babies. There	Thank you for your comment. In response to stakeholder feedback the committee agreed that that although risks seem to increase with

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Foundation Trust				is no data to support this as per Table 2. We would ask that supporting data be provided and if not the statement be removed.	an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this.
Chelsea & Westminster NHS Foundation Trust	Guideline	009	010	Recommendation 1.3.6 – This recommendation will be challenging in practice as it will likely lead to women having significant anxiety surrounding their risk when actually there is limited data to support this, most evidence showing no difference for most outcomes for women with BMI from 25 kg/m² upwards (as per the risk tables and evidence review). Any differences that were found in outcomes took place in an obstetric setting (why?) and no data exists for other place of birth settings except transfer in some cases, which is not an indication of poor outcome. By your own acknowledgement, you do not know if any differences found were about BMI, or birthplace. Therefore telling women in this BMI group that they are risky is unhelpful and untrue.	Thank you for your comment. In response to stakeholder feedback the committee agreed that although risks seem to increase with an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this. We have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The recommendation, the rationale and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different

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					places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them.
Chelsea & Westminster NHS Foundation Trust	Guideline	010	002	Recommendation 1.3.6 – stillbirth, neonatal death and baby needing neonatal care should be separated out from each other with context as to why such was needed. Combining them together when they are different outcomes that occur for different reasons has the potential to conflate the risk itself when trying to interpret it.	Thank you for your comment. We have used this phrasing as the studies reported the outcomes combined as a composite measure. We are unable to give the context as to why neonatal care was needed as we do not have that information available from the study. The committee agrees that individually the outcomes would provide more information regarding risk, however in this instance we were limited by the data that was reported in the included studies.
Chelsea & Westminster NHS Foundation Trust	Guideline	021	003	We are concerned about the term 'shared decision making' which contradicts other language around the importance of supporting the woman's (or birthing person's) right to make their own decision. It is not a shared decision, it is their decision and one that only they can make. We share evidence and clinical opinion/experience.	Thank you for your comment. This recommendation has, as you suggest, been amended to refer to supported decisions rather than shared decisions.
Chelsea & Westminster NHS	Guideline	022	001	We agree with the added support for the importance of communication and acknowledgement of their personalised care plan.	Thank you for your comment.

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Chelsea & Westminster NHS Foundation Trust	Guideline	026	021 - 022	The rationale for sterile water intracutaneous or subcutaneous for pain relief in women with back pain is supported by low to moderate studies. The additional training to ensure surgical site safety for the majority of midwives to perform this may influence uptake and offering it to women. However, we agree with offering this as an additional analgesic option for women.	Thank you for your comment. Although the evidence was classified using GRADE as low to moderate quality the committee agreed there was sufficient evidence of benefit to recommend it. Thank you for supporting this addition.
Chelsea & Westminster NHS Foundation Trust	Guideline	027	008	This recommendation will be challenging in practice due to the nature of opioids, which are controlled drugs that require medical prescription, securer storage then the addition of transporting and giving in a timely manner for women who choose birth at home.	Thank you for your comment. The committee recognise that this may be challenging to implement in practice but that some centres have procedures that allow the use of opioids in home births so this recommendation has not been amended.
Chelsea & Westminster NHS Foundation Trust	Guideline	027	019	We welcome the option of remifentanil PCA for all women who do not want an epidural	Thank you for your comment.
Chelsea & Westminster NHS Foundation Trust	Guideline	034	General	It is good to see advise regarding timings for assessment post spontaneous rupture of membranes at term	Thank you for your comment.

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Chelsea & Westminster NHS Foundation Trust	Guideline	035	General	It is good to have further clarity on the need to offer IOL as soon as possible or wait for up to 24 hours	Thank you for your comment.
Chelsea & Westminster NHS Foundation Trust	Guideline	037	020	We are concerned that this recommendation may be difficult to implement in practice due to the challenges of space and staff availability for early/latent labour care, which is often conducted in triage environments where footfall is considerable. It would be helpful to understand the rationale for why 1:1 care for 1 hour is recommended during an assessment in early labour.	Thank you for your comment. The recommendation for one-to-one care for at least an hour was made in 2014 (so is not a new recommendation) and was based on evidence which suggested this care led to an increase in spontaneous vaginal birth and a reduction on the need for epidurals.
Chelsea & Westminster NHS Foundation Trust	Guideline	038	007	1.8.6 The language could better reflect the consensus that the woman's views and decisions are vital to the process. We think that acknowledging that the woman may perceive herself as being in labour is extremely dismissive and discouraging of this phase. Her body is actively doing something, however it will end up. From our perspective, I think including a verbal acknowledgement of her physical and emotional expenditure, with language that recognises this, will help to remind professionals to be more encouraging,	Thank you for your comment. We have amended the language of this recommendation to make it more focused on offering the woman support and analgesia, as you suggest.

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				supportive and empowering for the women during these difficult hours.	
Chelsea & Westminster NHS Foundation Trust	Guideline	041 & 044	010 & 002	We agree with the addition of non-cephalic presentation, but would like face/brow presentation also in this.	Thank you for your comment. The committee agreed that face/brow presentation was included in 'non-cephalic' and so did not amend these recommendations.
Chelsea & Westminster NHS Foundation Trust	Guideline	045	009	We find the use of the language 'may' and 'consider' does not lead to a recommendation. We appreciate the intent to support the woman or birthing person to be able to make this decision for themselves however it offers no guidance. We are either concerned about insignificant meconium or we are not, or we are in some circumstances but not others – the guidance must be explicit or it is open to interpretation.	Thank you for your comment. The committee agreed that all meconium should trigger a discussion about the best place and type of care but this would vary depending on the character of the meconium, the woman's preferences and other risk factors, so the recommendation cannot be more prescriptive than this.
Chelsea & Westminster NHS Foundation Trust	Guideline	045	020	We find there is contradiction in what this statement means as with the use of the word 'option' it is open to interpretation. It should be made clearer that women with meconium should be recommended continuous CTG monitoring and so transfer to obstetric led care. The woman can decline that recommendation.	Thank you for your comment. The committee agreed that all meconium should trigger a discussion about the best place and type of care but this would vary depending on the character of the meconium, the woman's preferences and other risk factors, so the recommendation cannot be more prescriptive than this.
Chelsea & Westminster NHS	Guideline	048	General	We are supportive in the clarification of the frequency of contractions with oxytocin to be maintained at 3-4:10 and not more frequently	Thank you for your comment.

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Chelsea & Westminster NHS Foundation Trust	Guideline	053	007	We would like the guideline authors to consider differentiating the use of warm compress in women with and without epidural, as how will a woman with an epidural and altered perineal sensation judge warm. It would be useful to highlight perineal sensation may be altered and clinicians need to be very mindful of heat burns to the skin from warm compression especially if repetitively applied as recommended. However, in general we support the use of warm compress.	Thank you for your comment. The committee agreed that if the warm compress was held by the midwife at a comfortable temperature then it was unlikely to burn the woman.
Chelsea & Westminster NHS Foundation Trust	Guideline	053	011	We are concerned with the practice that might follow a recommendation for 'gentle stretching' of the perineum during birth and the resulting trauma this may cause tissues with clinicians stretching and swinging on the perineum.	Thank you for your comment. The recommendation has been amended to take out 'gentle stretching' as the evidence was considered for 'massage'.
Chelsea & Westminster NHS Foundation Trust	Guideline	053	014	This hands poised technique is in contradiction to the hands on technique being supported in hospitals using the OASIS care bundle.	Thank you for your comment. The committee reviewed the evidence for hand position again, and as it was low quality they agreed it was insufficient to provide guidance on the best hand position and so have removed this recommendation and instead just made a research recommendation.

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Chelsea & Westminster NHS Foundation Trust	Guideline	061	General	We are pleased to see the data re- risks of active vs physiological management of the 3rd stage to aid women in decision making	Thank you for your comment.
Chelsea & Westminster NHS Foundation Trust	Guideline	062	014	We are concerned with the safety of administering uterotonics before cord clamping has taken place and the impact this has on the benefits of delayed cord clamping.	Thank you for your comment. The committee agreed that administering uterotonics before cord-clamping was standard practice, and that it may even assist with delayed cord-clamping as the midwife would be occupied administering the oxytocin and would only then be available to clamp the cord.
Chelsea & Westminster NHS Foundation Trust	Guideline	070	004	1.11.2 We welcome the recommendation in assessment of the colour element of the Apgar score, which should reflect more positively for non-white babies. We would ask if NICE intends to align this with any Neonatal guideline and national tools and if not to consider this.	Thank you for your comment. The need to align the recommendations on Apgar score with other NICE guidelines will be passed to the NICE surveillance team who monitor guidelines to ensure they are up to date. However, there are currently no plans to review other national tools.
Ferring Pharmaceuticals	Guideline	093 062	013 023	We will request for the NICE Committee to take into consideration the published literature to support the efficacy and safety of the routine use of intramuscular carbetocin for prevention of postpartum haemorrhage at vaginal delivery. 1. **WHO Guidelines**: The use of an effective uterotonic for the	Thank you for your comment. The evidence review protocol is outlined in appendix A of evidence report M and the WHO guideline does not meet the inclusion criteria for this review protocol. However the review protocol notes that this guideline update is based on the Cochrane NMA and therefore this is listed as a key paper in the review protocol and the

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				prevention of PPH during the third stage of labour is recommended for all births. To effectively prevent PPH, only one of the following uterotonics should be used: oxytocin (Recommendation 1.1), carbetocin (Recommendation 1.2), misoprostol (Recommendation 1.3), ergometrine/methylergometrine (Recommendation 1.4), oxytocin and ergometrine fixed-dose combination (Recommendation 1.5). Recommended 1.2 The use of carbetocin (100 µg, IM/IV) is recommended for the prevention of PPH for all births in contexts where its cost is comparable to other effective uterotonics (please see also point 3 for the cost-effectiveness assessment on the specific UK context) 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 06-June-2023)	update of this Cochrane NMA formed the basis for this evidence review. We updated the Cochrane NMA to include more recently published papers such as the IMOX and CHAMPION trials as is stated in the evidence review section on included studies: 'A total of 220 randomised controlled trials (RCTs) were included in this evidence review. Most of these studies were identified from a published network meta-analysis (NMA) (n=196) (Gallos, 2018). A further 24 studies were identified by the updated literature search and included in the review." The CHAMPION trial, Widmer (2018) was included in the updated NMA undertaken for the guideline. Both Gallos (2019) and Matthijsse (2022) were included health economic papers in the economic evidence review and were considered by the committee.

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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 06-June-2023) 2. **Cochrane Network Meta-analysis**: Ergometrine plus oxytocin combination, carbetocin, and misoprostol plus oxytocin combination may have some additional desirable effects compared with the current standard oxytocin. The two combination regimens, however, are associated with significant side effects. Carbetocin may be more effective than oxytocin for some outcomes without an increase in side effects. The network meta-analysis included 196 trials (135,559 women) involving seven uterotonic agents, conducted across 53 countries (including high-, middle- and low-income countries). Most trials were performed in a hospital setting	

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				(187/196, 95.4%) with women undergoing a vaginal birth (71.5%, 140/196). 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). https://pubmed.ncbi.nlm.nih.gov/30569545/ (last accessed on 06-June-2023). 3. **Health Technology assessment**: a. For vaginal delivery, when assuming no adverse events, ergometrine plus oxytocin is less costly and more effective than all strategies except carbetocin. The strategy of carbetocin is both more effective and more costly than all other strategies. When taking adverse events into consideration, all prevention strategies, except oxytocin, are more costly and less effective than carbetocin. Ergometrine plus oxytocin, carbetocin and misoprostol plus oxytocin are more effective uterotonic drug strategies for preventing PPH than the current standard,	

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				oxytocin. Ergometrine plus oxytocin and misoprostol plus oxytocin cause significant side effects. Carbetocin has a favourable side-effect profile, which was similar to oxytocin. 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 06-June-2023). b. A recent study published the cost-effectiveness analysis of carbetocin versus oxytocin for the prevention of postpartum haemorrhage following vaginal birth in the United Kingdom across a cohort of 100 women; they concluded that the carbetocin utilization led to lower prophylactic treatment costs (total cost savings of £5,495) and less PPH events (3.42) versus oxytocin when utilized for the prevention of PPH following vaginal birth in the UK. Suzette Matthijsse et al. Cost-effectiveness analysis of carbetocin versus oxytocin for the prevention of postpartum hemorrhage following vaginal birth in the United Kingdom. J Med Econ 2022 Jan-Dec;25(1):129-137.	

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				https://doi.org/10.1080/13696998.2022.2027669 4. **CHAMPION Randomised Controlled Trial**: Heat-stable carbetocin was noninferior to oxytocin for the prevention of blood loss of at least 500 ml or the use of additional uterotonic agents. Noninferiority was not shown for the outcome of blood loss of at least 1000 ml. Widmer M, Piaggio G, Nguyen TM, Osoti A, Owa OO, Misra S, Coomarasamy A, Abdel-Aleem H, Mallapur AA, Qureshi Z, 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 06-June-2023)	
Ferring Pharmaceuticals	Guideline Evidence review M	093 137	014 K.1.3	The draft guideline states, that for women who had had a vaginal birth, the committee considered the use of carbetocin but the evidence was for intravenous carbetocin and the committee agreed that the routine use of an intravenous uterotonic in healthy women following vaginal birth was not appropriate and so they made a research recommendation for the use of intramuscular carbetocin.	Thank you for your comment. We recognise that the CHAMPION trial does provide evidence of the use of intramuscular carbetocin in vaginal birth in a large population of women (although a minority of carbetocin studies included in the review were intramuscular administration). Therefore, we have stood down the research recommendation and amended the rationale and committee's discussion of the evidence to

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				We will request for the NICE Committee to take into consideration the fact that the routine use of intramuscular administration of carbetocin is already approved by MHRA (UK) and HPRA (Ireland). Carbetocin (Pabal) has a marketing authorisation in UK and Ireland for the prevention of postpartum haemorrhage due to uterine atony at both caesarean section and vaginal delivery. For vaginal deliveries the recommended route of administration for carbetocin is both intramuscular and intravenous. . References: 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 06-June-2023) https://www.medicines.ie/medicines/pabal-100-micrograms-ml-solution-for-injection-34593/spc (last accessed on 06-June-2023).	reflect this change. We also note that the routine use of intramuscular administration of carbetocin is already approved by MHRA (UK) and HPRA (Ireland) and that carbetocin has a marketing authorisation in UK and Ireland. However, the committee made their recommendations based on considerations of clinical and cost-effectiveness. Based on the health economic analysis produced for this guideline, the committee did not consider that carbetocin was cost-effective for PPH prevention for women following vaginal birth. Whilst the effectiveness estimates from the NMA that informed the economic model did not distinguish by route of administration, we note that nearly all the evidence on the use of intramuscular carbetocin (85% of all subjects randomised to that treatment) comes from the CHAMPION trial which did not show intramuscular carbetocin to be more effective than oxytocin despite its higher cost.
Group B Strep Support	General	General	General	We note that the guideline uses nulliparous and multiparous as adjectives, this leaves out women who have given birth previously just once, who are parous but not multiparous. We suggest using nulliparous and parous,	Thank you for your comment. The guideline refers to multiparous as women who are in their second or subsequent pregnancy (so have given birth at least once and are now having a second baby). Our understanding of parous is that it refers to women who have just

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				and leave 'multiparous' for women who have given birth multiple times.	given birth once. This is also how we have classified and sub-divided the evidence where necessary so it would be confusing to change the terminology for the guideline as it would no longer reflect the evidence.
Group B Strep Support	General	General	General	It would be helpful if the guideline included instructions for the health professional about the administration of intrapartum antibiotic prophylaxis, including history-taking, obtaining details of known allergies, when to commence the intrapartum antibiotics. Please would you add this important information to the guideline?	Thank you for your comment. The detail relating to the use of intrapartum antibiotic prophylaxis is contained in the NICE guideline on Neonatal infection: antibiotics for prevention and treatment (NG195) and this includes details all the factors you have listed. This guideline is cross-referenced from several places in the intrapartum care guideline so this detail has not been repeated in the intrapartum care guideline.
Group B Strep Support	Guideline	General	General	We note the guideline uses the terms 'woman/women' and 'her/she' pronouns. We recognise the importance of using inclusive language such as 'birthing people' to remain sensitive to those whose gender identity does not align with the sex they were assigned at birth. Please would you amend the text to use additive and inclusive language?	Thank you for your comment. The new NICE style guide provides advice on additive language to be more inclusive, but this language is not currently being applied retrospectively to all existing guidance.
Group B Strep Support	Guideline	General	General	The guideline recommends the administration of intravenous antibiotics but does not include the implications of a cannula for the birthing person, and there are no instructions for the appropriate care of the cannula, for example,	Thank you for your comment. Explaining the need for an intravenous cannula would be part of the consent process for administering intravenous antibiotics. Appropriate care of a cannula is standard nursing and midwifery care

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				the importance of keeping it dry and undertaking VIP scoring on a regular basis. Please could this be added?	practice and does not need detailing in the NICE guideline for intrapartum care.
Group B Strep Support	Guideline	005	016	Please strengthen 1.1.3 by adding a bullet point to highlight some pre-existing conditions or previous obstetric history may impact the availability of birthplace options, for example, diabetes or birth of a previous baby affected by group B Strep disease, which may require a high level of monitoring throughout labour and birth or the facilities to administer intravenous products such as fluids or antibiotics.	Thank you for your comment. The pre-existing conditions or previous obstetric history that may impact on birthplace options are already covered in detail in section 1.3 on planning place of birth so have not been repeated here.
Group B Strep Support	Guideline	018	Table 12	Following the recognition of risk factors associated with group B Streptococcus where it is likely that antibiotics in labour will be needed, it is important to highlight what these risk factors are to enable clinicians to recognise correctly and promptly when the place of birth should be individually assessed. These can be obtained from the NICE Neonatal infection: antibiotics for prevention and treatment guideline, Section 1.2.1 https://www.nice.org.uk/guidance/ng195/chapter/Recommendations#risk-factors-for-and-clinical-indicators-of-possible-early-onset-neonatal-infection	Thank you for your comment. The wording of this line in Table 12 (now Table 8) has been simplified to state that it relates to the situation where intrapartum antibiotics are required for group B streptococcus.

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Group B Strep Support	Guideline	025	009	Rec 1.5.5 We're curious as to why the staff have this veto: "enable the woman's birth companion(s) to travel with her in the ambulance if that is what she wants and this is agreed by her care team and the ambulance crew."	Thank you for your comment. The committee agreed that the final decision about who could accompany the woman in the ambulance would be made by the ambulance crew as they would be aware of the space available, and would prioritise the needs of the woman.
Group B Strep Support	Guideline	034	001	Please include in the list of risk factors associated with prelabour rupture of membranes at term clarification of the time of rupture of membranes. It would be useful to enquire with the mother about the time of possible rupture of membranes as this would contribute to the identification of prolonged rupture of membranes, which may have implications in the care given in labour or in the postnatal period	Thank you for your comment. Ascertaining the time at which the membranes ruptured has been added to this recommendation as you suggest.
Group B Strep Support	Guideline	034	014	The following bullet point: 'History of group B streptococcus infection where a plan has been made for prophylactic antibiotics in this pregnancy' does not include group B Strep carriage in this pregnancy nor recognise a history of GBS in a previous pregnancy, both of which would indicate IAP should be offered. We suggest: "History of group B Streptococcus carriage or infection in this or a previous pregnancy where a plan has been made during the current pregnancy to offer	Thank you for your comment. The recommendation has been amended to include group B streptococcus in this or a previous pregnancy, as you suggest.

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				the woman prophylactic antibiotics before birth."	
Group B Strep Support	Guideline	035	012	Could the statement regarding the risk of neonatal infection in women with prelabour rupture of membranes at term versus those with intact membranes be changed from 'may increase over time' to 'will increase over time'? The NICE Neonatal infection: antibiotics for prevention and treatment guideline recognise confirmed prelabour rupture of membranes at term for more than 24 hours before labour as a risk-factor for early-onset neonatal infection. 'May increase over time' is a vague statement with no time frame for reference and may result in variability of care.	Thank you for your comment. The committee agreed that it was likely that the risk of infection would increase over time but as there was no definitive evidence for this increase they kept the terminology 'may'.
Group B Strep Support	Guideline	035	013 - 014	It would be helpful if the link in brackets of the second bullet point hyperlinks to 1.2.1 of the NICE guideline on Neonatal infection: antibiotics for prevention and treatment, identifying scenarios where women should be offered intrapartum antibiotics. Or taking into considering the list is short, could it be replicated and referenced here?	Thank you for your comment. The link in brackets will be hyperlinked in the published version of the guideline. Unfortunately in the pdf version of the guideline used at consultation the links are not live.
Group B Strep Support	Guideline	035	017	Following on from 1.7.6, we would suggest moving 1.7.11 "If a woman has a prelabour rupture of membranes at term (at or after 37+0 weeks) and has had a positive group B	Thank you for your comment. The recommendations subsequent to 1.7.6 (1.7.7 to 1.7.10) all relate to care of a woman who does not have group B streptococcus, so the

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				streptococcus test at any time in their current pregnancy….." to appear immediately afterwards. This would help to differentiate between the choices available to women with unknown/negative group B Strep status versus those with a known positive group B Strep status.	committee agreed it was clearer to keep those together, and then address the care of women who are group B streptococcus positive, so they have not reordered the recommendations.
Group B Strep Support	Guideline	036	018	This recommendation is great to see. We would like to see the recommendation extended to include the offering of immediate induction of labour/Caesarean birth to women who carried group B Strep in a previous pregnancy and to those whose previous baby developed a GBS infection, in view of their increased risk of group B Strep carriage (50%) and early-onset infection respectively. This is in reference to 2017 RCOG green-top guidelines on the Prevention of Early-onset Neonatal Group B Streptococcal Disease https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.14821 Section 5.3 and 5.4.	Thank you for your comment. The committee has amended this recommendation to add the group of women who have had a previous pregnancy where the baby developed group B streptococcus infection, as you suggest.
Group B Strep Support	Guideline	041	001 - 002	Please add the recommendation to offer intrapartum antibiotic prophylaxis where rupture of membranes is >24 hours, as prolonged rupture of membranes is a recognised risk factor for early-onset group B	Thank you for your comment. The recommendations in the section of the guideline on premature rupture of the membranes covers use of intrapartum antibiotics, so this has not been repeated here.

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				Strep infection, as stated in the RCOG's Greentop Guideline #36	
Group B Strep Support	Guideline	043	020 - 021	Please add the recommendation to offer intrapartum antibiotic prophylaxis if the mother is pyrexial as pyrexia is a recognised risk factor for early onset GBS infection, as stated in the RCOG's Greentop Guideline #36 and in the NICE Antibiotics for Neonatal Infection guideline.	Thank you for your comment. A hyperlink has been added to the NICE guideline on neonatal infection so that pyrexial women can be assessed as outlined in that guideline.
Group B Strep Support	Guideline	055	002 - 003	We feel it is important to recognise the recommendation in the RCOG's Greentop Guideline on group B Strep that birth in a pool is not contraindicated if the woman is a known group B Strep carrier provided she is offered appropriate intrapartum antibiotic prophylaxis. Could this be added in please?	Thank you for your comment. The committee did not review the evidence for which women can and cannot safely give birth in water and so did not make this change, but the recommendations on water birth are planned for an update when the POOL study is published and so it may be possible to provide more advice on this as part of that update. Please see: https://www.nice.org.uk/guidance/cg190/resources/2023-exceptional-surveillance-of-intrapartum-care-for-healthy-women-and-babies-nice-guideline-cg190-11443418173/chapter/Surveillance-decision?tab=evidence
Group B Strep Support	Guideline	075	001 - 003	This sentence could be modified to minimise the administration of antibiotics to babies with no clinical indication. We would suggest 'or the baby' to read "If there are no signs of	Thank you for your comment. The words 'or in the baby' have been added to this recommendation for clarity.

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				infection in the woman *or the baby*, do not give antibiotics to either the woman or the baby, even if the membranes have been ruptured for over 24 hours."	
Group B Strep Support	Guideline	075	004 - 006	The guideline would benefit from a section to address the clinical management of babies born to women carrying group B Strep in the current pregnancy and who did not receive >4+ hours intrapartum antibiotic prophylaxis or those who have had a previous baby with group B Strep infection. This consists of evaluation at birth for clinical indicators or infection and vital signs checked for 12 hours. Including this would increase the correct monitoring of babies born in such circumstances and reduce variation in practice.	Thank you for your comment. The recommendation has been amended to include possible signs of infection in the baby as well as in the mother, and the link to the neonatal infection guideline (already in place) will then provide further advice on management.
Healthcare Safety Investigation Branch	guideline	021	003	Rec 1.4.7 'ensure that the information given supports shared decision making'. HSIB considers that the term 'supported decision making' should be used, as decisions about a mother's/pregnant person's care should be theirs alone. This should be aided by information given by health care professionals	Thank you for your comment. This recommendation has, as you suggest, been amended to refer to supported decisions rather than shared decisions.
Healthcare Safety	guideline	021	007 - 008	'using interpreters who are independent of a woman rather than for example a family member or friend'.	Thank you for your comment. The committee agreed that it was best practice to always use an independent interpreter and so did not

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Investigation Branch				HSIB considers that mothers should also be able to choose who interprets for them and requests additional wording to reflect this possibility.	change their recommendation. However, they agreed that it would be a woman's right to decline the use of an independent interpreter and use a family member instead if they chose.
Healthcare Safety Investigation Branch	Guideline	026	020	Whilst we appreciate this section is in grey and therefore not for comment, we would appreciate a recommendation for staff caring for a mother in a birthing pool, to have a plan as to how the mother would be evacuated from the pool in the event of an emergency.	Thank you for your comment. The committee agreed that all units would have local guidance on how to evacuate a woman from a birthing pool and so this is not the level of advice that would be included in a NICE guideline.
Healthcare Safety Investigation Branch	Guideline	027	019 - 020	We recommend that the bolus dose of intravenous remifentanil is changed to '**up to** 40 micrograms per bolus', as the practice of many obstetric anaesthetists is to start with a bolus of 20 micrograms per bolus.	Thank you for your comment. The evidence upon which this recommendation was made used a dose of remifentanil 40 micrograms so the committee agreed this was the dose that should be advised. However, if anaesthetists, in their clinical judgement, want to start with a lower dose that would be an individualised decision for them to make.
Healthcare Safety Investigation Branch	Guideline	027	022	HSIB considers that remifentanil is used for several indications and is not **only** an option for women 'who do not want an epidural'. HSIB would welcome this to be reworded.	Thank you for your comment. This recommendation has been amended to state that remifentanil PCA can be an option for any woman who wants ongoing pain relief.
Healthcare Safety Investigation Branch	Guideline	032	011	In many units, midwives do not check leg strength and sensation following the insertion of an epidural. HSIB would welcome the wording in this recommendation to be changed to 'by a midwife trained to check this'.	Thank you for your comment. The recommendation has been amended to state that this decision must be made by a midwife trained in caring for women with epidurals, as you suggest.

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Healthcare Safety Investigation Branch	Guideline	034	001 - 022	HSIB investigations have found variation in assessment of risk factors during advice given at telephone triage after suspected rupture of membranes (ROM). HSIB welcomes NICE recommendations for immediate invitation for face-to-face assessment if the mother has any risk factors when she calls the telephone triage with suspected ROM	Thank you for your comment.
Healthcare Safety Investigation Branch	Guideline	034	008	HSIB notes the new guideline contains a reference to 'blood-stained liquor' as a risk factor for pre-labour membranes at term (in addition to the recommendations carried over from previous versions of this guideline for transfer to obstetric care if there is 'any vaginal blood-loss other than a show' (recommendations 1.8.11 and 1.8.20). However, HSIB investigations have found many instances where the finding of '**pink liquor'** throughout labour has not been recognised as being blood-stained liquor. The colour of the liquor has been 'normalised' by this unrecognised terminology. This has resulted in unsuspected placental abruption and poor outcomes for several babies (and in one case a maternal death). HSIB requests that consideration is given to providing additional guidance in NICE intrapartum guidance. This will support staff in risk	Thank you for your comment. The committee had been made aware that there were concerns over the use of the term 'pink liquor' and so did not use this term as they agreed it could be open to interpretation, as in some cases pink liquor was normal, but that in other cases lightly blood stained liquor would be defined as pink and so not acted upon. The committee therefore used the terminology blood-stained liquor in the section of the guideline on premature rupture of the membranes, and 'fresh blood or blood-stained liquor' in the sections relating to criteria for transfer to obstetric-led care. The committee agreed that this was a clear way of describing the colour of the liquor, and so should lead to more appropriate action, and allow better detection of any degree of haemorrhage.

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				assessing liquor, and acting in response to the observation of liquor that is not clear, and more specifically liquor that has been assessed as being 'pink'. We suggest at minimum this finding should lead to a holistic review to exclude significant causes of antepartum haemorrhage, prior to supporting a mother to continue in labour.	
Healthcare Safety Investigation Branch	Guideline	035	017 - 023	HSIB investigations have identified variation in the offer of immediate induction of labour or expectant management up to 24 hours, in women without complications who present with term prelabour rupture of membranes. HSIB welcomes the very clear advice given by NICE in this situation	Thank you for your comment.
Healthcare Safety Investigation Branch	Guideline	040	001 - 007	HSIB investigations have identified variation in documentation of findings at vaginal examination. HSIB welcomes this recommendation from NICE	Thank you for your comment.
Healthcare Safety Investigation Branch	Guideline	044 048	018 - 020 022 - 024	HSIB welcomes the recommendations for fluid balance monitoring if there is absent bladder sensation. HSIB also welcomes the recommendation that staff should not start separate intravenous fluids without a clinical indication; and that fluid balance monitoring should start when intravenous oxytocin is started. HSIB investigations have found several cases where mothers received large	Thank you for your comment. Unless otherwise stated, all the recommendations for intrapartum care apply in all settings so this has not been added to the recommendation. The committee agreed that adding these new recommendations on bladder care would lead to more standardised care and reduce the risk of hyponatremia, and the reason for adding

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				quantities of fluid in labour- either by an oral route, in midwife-led settings (including homebirth); or by the intravenous route; or a combination of the oral and intravenous routes. Most of these cases did not have fluid balance recorded and resulted in symptomatic hyponatraemia in both mother and baby (including cases of seizures in mothers and babies). HSIB would welcome a recommendation from NICE, that fluid balance should be monitored for mothers labouring in **all birth settings**, (including midwife-led settings) in order to reduce the incidence of peripartum hyponatraemia. In addition, HSIB consider that it would be beneficial if NICE discussed the reasons for this recommendation, as awareness of this condition, whilst increasing, is still not embedded amongst maternity staff.	this recommendation is given in the hyperlinked explanation in Table B.
Healthcare Safety Investigation Branch	Guideline	048	025 - 027	HSIB investigations have found many instances where fetal compromise secondary to uterine hyperstimulation have contributed to poor outcomes in babies. HSIB welcomes the NICE recommendation that oxytocin use is titrated to a frequency of contractions occurring 3-4 in 10 minutes.	Thank you for your comment.

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Healthcare Safety Investigation Branch	Guideline	053	008	HSIB welcomes advice from NICE regarding the use of warm compresses in labour to reduce perineal trauma	Thank you for your comment.
Healthcare Safety Investigation Branch	Guideline	053	014 - 017	Whilst NICE is not specifically recommending that birth attendants assist birth of the presenting part at the end of the second stage of labour with a 'hands poised' technique, there is an implication that this should be followed. We feel that this contradicts the current RCOG recommendation from the OASI Care Bundle course which recommends manual perineal protection, and to 'support the perineum throughout the whole birth' (RCOG OASI Care Bundle course 3: Full course for professionals)	Thank you for your comment. The committee reviewed the evidence for hand position again, and as it was low quality they agreed it was insufficient to provide guidance on the best hand position and so have removed this recommendation and instead just made a research recommendation.
Healthcare Safety Investigation Branch	Guideline	057	026 - 029	HSIB investigations have found a few instances where there is confusion regarding oxytocin infusion regimes for labour. HSIB would welcome a suggested oxytocin regimen within the NICE guidance.	Thank you for your comment. The precise details of how the dose should be increased are in the Summary of Product Characteristics for oxytocin so are not repeated in the guideline.
Healthcare Safety Investigation Branch	Guideline	061	001 - 013	HSIB welcomes data from NICE for counselling of women about the risks of active versus physiological management of the third stage of labour	Thank you for your comment.

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Healthcare Safety Investigation Branch	Guideline	062	010 - 011	The correct dose for oxytocin bolus for active management of the third stage, is either **10 IU IM or 5 IU IV,** as recommended in the British National Formulary.	Thank you for your comment. This has now been corrected to 5 units for intravenous administration.
Healthcare Safety Investigation Branch	Guideline	069	003 - 005	Whilst HSIB welcomes the addition of tranexamic acid for treatment of postpartum haemorrhage, we consider the threshold for giving this drug ('for managing continuing postpartum haemorrhage.') is not clear within the NICE guidance. HSIB would welcome clearer guidance for when to give tranexamic acid – for example, when blood loss reaches 500 ml.	Thank you for your comment. Tranexamic acid should be given in all cases of postpartum haemorrhage (PPH) in addition to uterotonics and this is clear in the recommendation. The repeat doses are in cases of ongoing PPH and the recommendation has been split into 2 sentences to make this clear.
Healthcare Safety Investigation Branch	Guideline	070	001 - 008	HSIB investigations have found that there may be variation in the assessment of Apgar scores in newborn babies. Our investigations of babies who experience sudden unexpected postnatal collapse, have found that some Apgar assessments which preceded this collapse, were performed from the 'end of the bed' or from 'across the room'. HSIB would welcome further detail in the NICE guideline in how to assess Apgar scores, for example looking directly at and touching the baby to assess the separate components of the Apgar score.	Thank you for your comment. As the requirement to assess the Apgar score now involves looking inside the baby's mouth, the committee did not think it would be possible to do without touching the baby, and so did not make further changes to the recommendation.
Healthcare Safety	Guideline	071	006 - 009	HSIB's national learning report 'Neonatal collapse alongside skin-to-skin contact'	Thank you for your comment.

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Investigation Branch				(2020)' highlighted that a baby should be routinely monitored while in skin-to-skin contact with the mother or father; and that checking that a baby's position such a that a clear airway is maintained, by observing respiratory rate and chest movement, is important. HSIB welcome this new recommendation about the importance of protecting the baby's airway during skin-to-skin contact.	
Lewisham Maternity Voices Partnership	Guideline	031	006	The proposed recommendation that women should be provided with information regarding the potential for complications during insertion of an epidural to "cause a severe post natal headache" is "based on the committee's knowledge and experience" (as stated in the column alongside paragraph 1.6.24). However, we believe that all recommendations for service-users should be fully evidence-based. The committee is a relatively small group and as such it would not be possible for members to have comprehensive knowledge of all maternity issues across all maternity settings in a manner that is controlled for differing factors that could influence outcomes. We therefore believe that this line of the recommendation should be removed or, if it is retained, that it	Thank you for your comment. We agree that an evidence-based update to the section on regional analgesia would be the ideal. However, this section of the guideline was not prioritised for an evidence-based update, but the recommendations on regional analgesia were made in 2007 and the committee were aware that practice has moved on since then. They were aware of an increasing body of evidence that suggests there is a risk of a severe postnatal headache as a complication of epidural use. The committee agreed that it was preferable to add this information to the guideline based on their knowledge and experience so that women were warned about this and could take it into consideration when making a decision about epidural use, rather than wait until a full evidence-based update of

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				should be made clear in a prominent position what the rationale is for the recommendation.	this section can be carried out, which may be some months or longer away.
Lewisham Maternity Voices Partnership	Guideline	031	007	The proposed recommendation that women should be provided with information regarding the potential for complications during insertion of an epidural to "cause a severe post natal headache" is "based on the committee's knowledge and experience" (as stated in the column alongside paragraph 1.6.24). However, we believe that all recommendations for service-users should be fully evidence-based. The committee is a relatively small group and as such it would not be possible for members to have comprehensive knowledge of all maternity issues across all maternity settings in a manner that is controlled for differing factors that could influence outcomes. We therefore believe that this line of the recommendation should be removed or, if it is retained, that it should be made clear in a prominent position what the rationale is for this recommendation.	Thank you for your comment. We agree that an evidence based update to the section on regional analgesia would be the ideal. However, this section of the guideline was not prioritised for an evidence-based update, but the recommendations on regional analgesia were made in 2007 and the committee were aware that practice has moved on since then. They were aware of an increasing body of evidence that suggests there is a risk of a severe postnatal headache as a complication of epidural use. The committee agreed that it was preferable to add this information to the guideline based on their knowledge and experience so that women were warned about this and could take it into consideration when making a decision about epidural use, rather than wait until a full evidence-based update of this section can be carried out, which may be some months or longer away.
London Neonatal Operational Delivery Network	Guideline	General	General	Welcome the repetitions of the importance of skin to skin and avoidance of separation.	Thank you for your comment.

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London Neonatal Operational Delivery Network	Guideline	General	General	This hasn't been included in the review but it would be good to see more of a focus on trauma-informed care (preventative, reparative and reductive) and compassionate care as mentioned in the joint 3-year plan.	Thank you for your comment. Trauma-informed care was not included in the scope of this update but your comment will be passed to the NICE surveillance team who monitor guidelines to ensure they are up to date.
London Neonatal Operational Delivery Network	Guideline	071	017 - 018	The head circumference and birth weight should be recorded on a centile chart at this time as well, so that any unexpected small for gestational age or fetal growth restricted baby can be diagnosed. This should be followed by appropriate advice for measuring blood sugars (baby <0.4th centile), observation on Newborn Early Warning Trigger and Track tool (NEWTT), close attention to normothermia etc (British Association of Perinatal Medicine (BAPM) guidance could be referred to here too).	Thank you for your comment. The need to plot the head circumference and birthweight on a centile chart and check that the babies temperature is normal have been added to the recommendation. The committee agreed that it was not necessary to provide details on the actions to be taken (for example measuring blood sugar for small babies) as this would be carried out under supervision of paediatrics, and was not in the scope of intrapartum care.
London Neonatal Operational Delivery Network	Guideline	075	026 - 027	This is not a new recommendation but needs more explanation to make it possible to implement (and this is important given that suicide remains the leading cause of maternal death).	Thank you for your comment. A link has now been included to the NICE guideline on postnatal care, which provides more details on the actions to be taken if there are concerns about a woman's emotional or psychological condition after the birth.
London Neonatal Operational Delivery Network	Guideline	079	022	Can you add something about normalising any distress and providing psychologically informed care at this time, and signposting to relevant services (GP, IAPT, maternal mental health services)	Thank you for your comment. A link has now been included to the NICE guideline on postnatal care, which provides more details on the actions to be taken if there are concerns

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					about a woman's emotional or psychological condition after the birth.
London Neonatal Operational Delivery Network	Guideline	094	026	NICE have not made a recommendation on the position of the baby with cord clamping vaginal level vs on the abdomen (as the trials show no clear evidence and only these positions have been studied). NICE have said "Overall, the committee came to the consensus agreement that the effects on haemoglobin were unclear, but the evidence suggested that holding the baby at abdominal level during delayed cord clamping might have an adverse effect on haemoglobin levels but that the effect was likely to be very small and may or may not be clinically significant" There is no mention of the position of elevation above the abdomen/vagina (commonly to show the baby to the mother, especially at C section). This elevated positioning of the baby immediately at birth above the vagina/ abdomen is unstudied and may be physiologically disadvantageous with respect to Hb and haemodynamic preload. As neonatologists here we discourage this and babies should be in the studied positions	Thank you for your comment. There was no evidence that allowed the committee to make recommendations about the position of the baby, and instead they made a research recommendation. The PICO table for this research recommendation (in appendix K of evidence review N) has been expanded to include positions higher than the mother's chest level to address this point that you have raised.

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				of vaginal level/ on the abdomen during cord clamping.	
London Neonatal Operational Delivery Network	Guideline	096	010	First paragraph - this seems vital and it would be helpful to have this further up in the guidance. The evidence from reviews such as Ockenden and Kirkup is that communciation and emotional care was often lacking so it would be important for staff to read this rather than having to wade through the guidance.	Thank you for your comment. Although the context section appears at the end of the pdf document used for consultation once the guideline is live on the NICE website it can be accessed from a menu and so readers do not have to read the whole guideline to reach it.
Maternal Mental Health Alliance	Guideline			Section 1.16 (care of woman after birth). This section states 'Early assessment of the woman's emotional and psychological condition in response to labour and birth'. It does not state any action that should be taken regarding onward referral if deemed necessary (such as referral to a perinatal mental health team) or 'red flag' symptoms such as high levels of maternal distress regarding the birth or initial disinterest in baby from the mother. Other sections of the guideline discussing physical complications **are** specific about the responsibility to refer on for specialist assessment and note specific 'red flag' symptoms. Mental health complications should be treated equally to physical health complications in the guideline.	Thank you for your comment. A link has now been included to the NICE guideline on postnatal care, which provides more details on the actions to be taken if there are concerns about a woman's emotional or psychological condition after the birth.

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National Childbirth Trust	Evidence review A	007	001	In table 1 neonatal admission is shown as a critical outcome. However, Li et al, 2015, state "*The babies of 'higher risk' women who plan birth in an OU appear more likely to be admitted to neonatal care than those whose mothers plan birth at home, but it is unclear if this reflects a real difference in morbidity."* While we acknowledge that women will want to understand the chance of their baby needing neonatal care, the data is not currently clear about the difference between those babies who have a clinical need, and those babies who are admitted as a precaution. Therefore, this could inflate the *'risk'* of this critical outcome.	Thank you for your comment. The committee discussed that women are concerned about separation between them and their baby and take this into account when planning their place of birth. Admission to neonatal care as an outcome reflects this risk of separation between a woman and her baby, as well as the morbidity of the baby. We agree that this outcome alone may not address all aspects of morbidity and the outcome shoulder dystocia was included as well. Again this does not cover all morbidity, however we are limited in the number of outcomes we include in each review. We have added some additional text in the section 'the outcomes that matter most' to reflect the point you have raised.
National Childbirth Trust	Evidence review A	007	001	Table 1 shows transfer as an important outcome. Transfers are known to be higher in primiparous women or those with no previous vaginal birth (Brocklehurst et al, 2011; Rowe et al 2012; Rowe et al 2015), without strong evidence that the transfer made a difference in outcome. Transfer should be recognised as a precaution rather than as an objective measure of morbidity, and perhaps framed as protective rather than a 'risk'.	Thank you for your comment. The committee agreed that this outcome would indicate whether there had been any complications that could not be dealt with at the planned place of birth, and that for many women needing to be transferred to another location during labour was a very unpleasant experience that they would wish to avoid, so was usually viewed as a risk and was considered by the committee to be an important outcome for this review. They recognise that this outcome does not highlight the reasons for or outcome of the transfer and the evidence did not provide this level of

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					detail. The details of transfer rates from home to an obstetric unit for nulliparous and multiparous women have now been included (in the tables which are now in appendix B of the guideline) for clarity, and demonstrate, as you suggest, that transfer rates are much higher in nulliparous women. Women can therefore now take this into consideration when deciding on their place of birth.
National Childbirth Trust	Evidence review A	014	026	This feels unduly confident in a causative clinical link between BMI and intervention, rather than considering if the data includes precautionary or risk-averse practice. Is there a missing link, i.e., higher BMI –> issue leading to treatment –> treatment, and are we going from higher BMI to treatment too easily and without addressing the issue (which may or may not be clinical)?	Thank you for your comment. This paragraph states the relationship seen in the data, that as the BMI increases, so does the risk of an intrapartum intervention or an adverse outcome. We do not state the direct causes of this relationship and agree there may be a number of factors involved in this relationship. However, the committee feel it is necessary to inform women that a higher BMI may mean that the risk of interventions is increased. The reasons behind this relationship are not covered in this review.
National Childbirth Trust	Evidence review A	014	040 - 043	It will be important to include protective factors such as multiparity and other health within these conversations. *"Guide*" feels more directive than supportive (though we acknowledge some women prefer guidance).	Thank you for your comment. This review included parity (where the data were available broken down by parity) so women can consider their risks based on their BMI and parity. However it did not include other health factors that may impact on a woman's decision about her planned place of birth as these are covered

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					in the subsequent recommendations which include other medical and obstetric factors which can impact on planned place of birth. We have changed the wording from 'guide' to 'support' to be more woman-centred rather than directive as you have suggested.
National Childbirth Trust	Evidence review A	014	047	"*Could not establish a BMI range cut-off*" and yet have given such a cut-off in the draft guidance and media release.	Thank you for your comment. The phrase you quote is in relation to the committee not making a recommendation that specifies a particular BMI range cut-off above which planning birth in a specific setting is not recommended. The committee now recommend that having a BMI at booking of 35 kg/m^2 or more may be associated with more risks, however the recommendation does not specify where these people should plan their place of birth. Based on feedback from other stakeholders the recommendation around increased risk has been amended to clarify that although risks increase as BMI increases, a BMI of 35 kg/m^2 is the BMI at which this becomes particularly apparent across a range of birth settings and outcomes.
National Childbirth Trust	Evidence review A	014	049	Including mediating factors in these tables, e.g., parity, otherwise good health, otherwise poor health, would help women understand their personal context.	Thank you for your comment. This review included parity (where the data were available broken down by parity) so women can consider their risks based on their BMI and parity. However it did not include other health factors

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					that may impact on a woman's decision about her planned place of birth as these are covered in the subsequent recommendations which include other medical and obstetric factors which can impact on planned place of birth.
National Childbirth Trust	Evidence review A	014	049	Including icon arrays would support informed decision-making. These should include all planned birth locations and use Home as the baseline since all other locations require in-labour transfer.	Thank you for your comment. Unfortunately we think the evidence from this review, based on different BMIs, different parities, different settings and different outcomes does not lend itself easily to an icon array and the included risk tables are the most simplified format for the presentation of this complex data.
National Childbirth Trust	Evidence review A	015	017	Good to include information for women with BMI <18.5kg/m2. We suggest this is extended to all tables within the guidance to be more inclusive.	Thank you for your comment. We have included some information on key outcomes in the summary tables for women with a BMI <18.5 kg/m^2 for completeness, but for most of the outcomes there was no difference between this group and women in the healthy BMI range (18.5 to 24.9 kg/m^2). The full evidence for this group is available in the hyperlinked evidence report A.
National Childbirth Trust	Evidence review A	015	025	We feel it's important to recognise that *"more likely to have*" is not the same as *"more likely to need*". Ideally, data would be gathered for interventions that were later found to have been unnecessary, to help inform future practice. For example, the suspected *'large'* baby who when born was an average size.	Thank you for your comment. We have used the phrase 'more likely to have' because based on the evidence available for this review question, we only have data available for the incidence of the outcome. We cannot comment on whether or not the intervention was later found to be unnecessary as we have not

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					looked at that data. We have therefore not made changes to our wording in this instance.
National Childbirth Trust	Evidence review A	015	026	It is important to separate parity. Hollowell et al 2014 conclude: "*Otherwise healthy multiparous obese women may have lower intrapartum risks than previously appreciated. BMI should be considered in conjunction with parity when assessing the potential risks associated with birth in non-obstetric unit settings."* While this is for women with a BMI 35+ there is no reason women with a lower BMI would not show a similar effect.	Thank you for your comment. The evidence relating to this point has been discussed in a later paragraph of the committee's discussion of the evidence as it relates to the evidence comparing BMI more or less than 35 kg/$m^{2.}$ This paragraph highlights that increased risks were seen for nulliparous women in the higher BMI range but not multiparous women. These data have now also been included in the summary tables (now in appendix B of the guideline) to show this point, and in the amended recommendation.
National Childbirth Trust	Evidence review A	015	047	We feel it's important to recognise that *"more likely to have*" is not the same as *"more likely to need*". Ideally, data would be gathered for interventions that were later found to have been unnecessary, to help inform future practice. For example, the suspected *'large'* baby who when born was an average size.	Thank you for your comment. We have used the phrase 'more likely to have' because based on the evidence available for this review question, we only have data available for the incidence of the outcome. We cannot comment on whether or not the intervention was later found to be unnecessary as we have not looked at that data. We have not made changes to our wording in this instance.
National Childbirth Trust	Evidence review A	015	050	Is there good data that this transfer is for a clinical need, rather than as a precaution? Telling women and health professionals that there is an increased transfer rate could support informed decision-making but may	Thank you for your comment. We do not have data on the reasons for transfer, therefore we have not specified why the women were transferred. We specified the outcome of 'transfer to obstetric unit' in the protocol to

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				also lead to additional pressure to transfer or to birth in the OU.	inform women who are planning their place of birth of the risks of transfer to an obstetric unit, as many women find that needing to be transferred to another location during labour was a very unpleasant experience that they would wish to avoid. This risk is presented in the evidence review and in the summary tables in the guideline (now in appendix B).
National Childbirth Trust	Evidence review A	016	005	NCT is unsurprised at this effect, which reinforces what we commonly hear.	Thank you for your comment.
National Childbirth Trust	Evidence review A	017	009	We applaud the decision to remove a hard cut-off, which allows the service to work with their local demographic while also respecting women's informed decision-making. However, at present this would lead to a longer appointment with a Consultant Midwife or Senior Midwife (C/SMW) to discuss the woman's individual situation. We are concerned that either the C/SMW becomes overwhelmed with referrals of women with BMI 25+, or that the opportunity will not be offered to women and her usual midwife uses the guidance to 'tell' rather than 'discuss' in what is normally a time-pressured routine appointment.	Thank you for your comment. Based on feedback form yourself and other stakeholders, the recommendation now advises that although risks seem to increase as BMI at booking increases, this is particularly the case for women with a BMI above 35 kg/m^2. As this represents a smaller population than all women with a BMI above 25 kg/m^2 then we think this will reduce the pressure on midwives.

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National Childbirth Trust	Evidence review A	017	016	Increasing interventions and adverse outcomes are here assumed to be caused by BMI despite a lack of good quality evidence. We feel that some interventions may be due to caution rather than clinical need.	Thank you for your comment. This paragraph states that as the BMI increases, so does the risk of an intrapartum intervention or an adverse outcome, but there is no suggestion of causality. We agree there may be a number of factors involved in this relationship, and this review provided data on different outcomes at different places of birth for women of different parity and different BMI, but was not aimed at exploring the reasons for increased interventions.
National Childbirth Trust	Evidence review A	017	021 - 023	Excellent.	Thank you for your comment.
National Childbirth Trust	Evidence review A	017	025 - 027	The guideline will be applied to individual women, not populations, so we feel it is not sufficient to accept a 'representative' proportion of Black, Asian and other minority ethnic groups in the data as applicable to all. Perhaps better to acknowledge that the data is not currently available for a fully informed decision and seek to rectify that with research. We are also concerned by the assumption in the BMI guideline, that it is BMI rather than other factors such as weathering, which is the cause of morbidity in these populations.	Thank you for your comment. This text has been amended as you suggest to state that no data were available broken down for different ethnic groups. As there was no data for these groups no suggestions have been made about the cause of morbidity in these populations.

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National Childbirth Trust	Evidence review H	006	008 - 012	We would encourage the committee to attempt directed pushing as they describe it: "women are encouraged to take a deep breath in at the beginning of the contraction and push throughout the duration of each contraction". Do they find it easy to hold a single breath and push for the typical length of an expulsive contraction (say 90 seconds)? We suggest rephrasing to "women are encouraged to take a deep breath at the beginning of the contraction, and push to the end of that breath, taking further breaths as necessary and repeating to the end of the contraction." We would also encourage research which includes place of birth, position, and separates open and closed glottis breathing (as selected by the woman rather than randomised, as we feel this would be unethical).	Thank you for your comment. This description in the introduction to the evidence review has been changed as you suggest.
National Childbirth Trust	Guideline	General	General	We feel the strength of meaning is unclear, and something has been lost in moving to wording ('offer/consider') rather pointing to certainty of evidence. We would like to see NICE fully adopt the GRADE system by using labels as illustrated in Cochrane's 'How to grade' on p20 **in addition to** the language of 'offer/consider'. For example, '*Offer [intervention] (High)*', or *'Consider*	Thank you for your comment. The certainty of the evidence for each outcome is assessed using GRADE. The details of this assessment are provided in the evidence report which backs up the new recommendations where evidence reviews have been carried out. However, the NICE style does not yet use the individual labels for recommendations as you suggest.

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				[intervention] (Very low)'. This will ensure the guidelines are accessible to women and their families and will support making an informed decision. Importantly, this labelling should extend to the published 'Information for the public'.	
National Childbirth Trust	Guideline	General	General	For future reference it would be helpful if, in the main text of the guideline under 'Why the committee made the recommendation', : 1. It was clear whether the recommendation is based on a systematic review (and how many studies and what type of studies) or a single study, and how many participants were included. 2. the findings could be shown in the form of a 'relative risks' (RR) or odds ratios (OR) or mean differences (MD) or standardised mean differences (SMD), and the confidence interval (CI). 3. links were provided to the specific Forest Plot and specific GRADE assessment so readers can quickly access this information. The first NICE Intrapartum Care Guideline of September 2007, reported in the results in this way (although GRADE was not available then) and it was much clearer for readers to understand, as currently it is very difficult to trace the evidence behind any specific recommendation being made. We would	Thank you for your comment. When the guideline is published on the NICE website, each new recommendation or set of recommendations will be followed by a box which contains hyperlinks to the brief rational and impact section and also to the detailed evidence review, so users of the guideline will be able to click through directly to the evidence behind each recommendation, including the statistical results in the GRADE tables and Forest plots.

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				suggest looking at and using the PRISMA reporting guidelines for systematic reviews and the EQUATOR CONSORT statement for the reporting findings for the relevant methodology.	
National Childbirth Trust	Guideline	General	General	When communicating risks, putting the *"so this does not happen in ..."* in a separate column, rather than in parentheses, would be more balanced. Using icon arrays to provide a visual guide would be very helpful.	Thank you for your comment. In order to make tables as accessible as possible (for example so screen readers can read them) it is preferable to contain the text in one box. We will pass on your comment about using icon arrays to the NICE team who plan implementation support.
National Childbirth Trust	Guideline	General	General	To make language even more person-centred, we prefer: . the use of "informed decision-making" over "shared decision-making", as while the health professional can suggest or recommend, the only person who can accept is the person whose body it affects. . "discuss with the woman" rather than "inform the woman" And suggest the (unborn or born) baby is referred to as "her baby" (or "their baby"). Referring to their children in this way strengthen the narrative around decision making belonging to women.	Thank you for your comment. The wording 'shared decision-making' has been changed throughout the guideline to 'supported decision-making', and the need to have discussions and not just 'inform women' has been changed in a number of places. The committee agreed that it is clear the baby belongs to the woman and it was not necessary to state this throughout the guideline.

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National Childbirth Trust	Guideline	General	General	Conversations about decision-making need to avoid distracting her from her coping strategies. They should be: . at the woman's level (not standing over her) . concise, clear and simple . refer to previous discussions, i.e., having taken place antenatally and recorded in her notes . acknowledging that situations and preferences change . seeking her feelings first can involve the birth partner as a mediator if agreed at the onset of care.	Thank you for your comment. The points you have raised are now covered in existing and new recommendations in the sections of the guideline on antenatal education, communication, and care throughout labour.
National Childbirth Trust	Guideline	General	General	We would like to see the impact on breastfeeding (none, some, significant) referred to for all interventions, as this could be an unexpected effect, and could form a part of the woman's decision-making process.	Thank you for your comment. Breastfeeding was considered as an outcome in a number of evidence reviews, and where evidence was available it is recorded in the evidence reviews and was considered by the committee when agreeing recommendations. However, for many interventions there was no evidence on the impact on breastfeeding and so it would add little additional information to help women make their decisions.
National Childbirth Trust	Guideline	General	General	Tables: Several tables have large gaps with 'no data', with no explanation as to why there is no data.	Thank you for your comment. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in

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				We would like to see consistent inclusion of 'Less than 18.5'	the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The evidence for less than 18.5 has been included in the table with data for women of mixed parity where it was available.
National Childbirth Trust	Guideline	016 - 019	Tables 10 - 13	We are glad to see that the list of medical conditions suggesting planned birth in obstetric unit has been updated.	Thank you for your comment.
National Childbirth Trust	Guideline	006	003 - 004	To balance with the addition in line 5-6, emphasise that the woman can also revisit her plans, and "changes occurring" is not limited to problems with pregnancy but could also be to do with service provision or other aspects of the woman's life. Propose amending from "they are free to change their mind at any time, including during labour or while giving birth" to "they are free to discuss again, and change their mind at any time, including during labour or while giving birth". This leaves the door open for revisiting the information discussed.	Thank you for your comment. The wording of this recommendation as been revised to emphasise that women can make decisions, and change their mind, at any time. The committee did not agree that the phrase 'discuss again' should be used as women may feel pressured if they are asked to revisit decisions multiple times.
National Childbirth Trust	Guideline	006	005 - 006	We feel this is a good addition	Thank you for your comment.

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National Childbirth Trust	Guideline	007	013 - 014	Suggest adding: "If all four places of birth are not available within the Trust, advise women that they are able to access neighbouring Trusts who do offer more choice"	Thank you for your comment. The guideline provides recommendations to advise on the best possible clinical care, and this should include the option of birth in all four places of birth. There may be situations where operational aspects need to be taken into consideration when implementing these recommendations in individual cases but the committee agreed it was not within the remit of the guideline to provide advice on operational issues, and that other options such as partnering with adjacent Trusts may need to be considered locally.
National Childbirth Trust	Guideline	009	008 - 010	We have concerns about this recommendation: *"Advise women that having a BMI at booking of 25 kg/m2 or more may be associated with increased risks for them and their baby, and that they should take this into account when planning their place of birth. Use tables 2, 3, 4 and 5 below to discuss these risks with women. [2023]"*. While it aims to be transparent with women about the likelihood of various events, we believe it will lead to more women being directed to obstetric units. • The draft text implies that the risks are predicated solely on BMI, and that they are sufficient to warrant	Thank you for your comment. In response to stakeholder feedback the committee agreed that that although risks seem to increase with an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this. We have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so

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				consideration of place of birth. This is at odds with the rationale on p84, which states *"the committee were unable to determine if the risks were related solely to increased BMI or were affected by the planned place of birth".* • Despite creating a new intervention at a BMI of 25+, the only supporting data provided for women with BMI 25-29.9 is for caesarean birth, and for 30-35 for transfer and caesarean birth. • There is no distinction in the draft text between nulliparous and parous women. Hollwell et al, 2014 refer to a *"modest"* increased risk of augmentation and intrapartum caesarean for otherwise healthy women with BMI 35+, but still lower than nullip women of healthy weight, and concluded *"Otherwise healthy multiparous obese women may have lower intrapartum risks than previously appreciated. BMI should be considered in conjunction with parity when assessing the potential risks*	complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The recommendation, the rationale and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them.

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				associated with birth in non-obstetric unit settings." • There is no acknowledgement that place of birth can be the cause of some additional interventions: Brocklehurst et al, 2011 highlighted that planned place of birth affected rates of intervention for 'low risk' women. Li et al, 2015 stated *"The babies of 'higher risk' women who plan birth in an OU appear more likely to be admitted to neonatal care than those whose mothers plan birth at home, but it is unclear if this reflects a real difference in morbidity".* • There is no distinction between otherwise healthy women and those with co-morbidities • There is also no acknowledgement of the different calculation of BMI for some ethnicities, and therefore how this may disproportionately affect some women. • In an ideal world, good conversations between HCPs and women would address individual factors, but we	

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				doubt that an already overstretched service will provide this level of discussion. We query whether many Trusts would be able to support the increased numbers of women using obstetric services if the BMI threshold was reduced to 25.	
National Childbirth Trust	Guideline	019	Table 13	We are glad to see that the maternal age to *'consider'* has been increased from 35 to 40.	Thank you for your comment and support for this change.
National Childbirth Trust	Guideline	020	004	We applaud the reference to the guideline on shared decision making, and this could also include GMC Decision making and consent.	Thank you for your comment and support for this link to the NICE guideline on shared decision-making. The committee did not agree that it was necessary to also include a link to the GMC document on the same topic.
National Childbirth Trust	Guideline	020	026 - 028	We welcome the recommendations on communication. We suggest amending *"use clear language"* to *"use language which is clear to the woman"* would put the woman at the centre and avoid any misunderstanding.	Thank you for your comment. This has been changed to '…clear to the woman' as you suggest.
National Childbirth Trust	Guideline	021	003 - 004	We applaud this amendment, and in future would like to see this move towards *"sharing information to support the woman's informed decision-making".*	Thank you for your comment. This recommendation has, as you suggest, been amended to refer to supported decisions rather than shared decisions.
National Childbirth Trust	Guideline	026	001	We applaud the acknowledgement that some women will wish to use TENS	Thank you for your comment.

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National Childbirth Trust	Guideline	026	007	We feel it is not appropriate to mention that "other analgesia may still be needed" for only one form of pain relief, given this is true of all forms. We suggest that after 1.6.1 a paragraph is added "discuss with women during pregnancy and early labour that pain is an individual experience and women may find they would like to use a variety of options to stay comfortable during the birth of their baby" Then at this point replace "other forms of analgesia may still be needed" with "describe other forms of analgesia that could be used alongside TENS if desired", and add "If a woman wants to use TENS to manage her comfort during labour, support her choice", as this is used after other forms of pain relief	Thank you for your comment. The wording of this recommendation has been changed to 'if a woman wants to use TENS to manage her comfort during labour, support her choice' as the committee agreed this is more woman-centred. The wording of last bullet has also been changed to advise that other forms of pain relief can be used with TENS, as you suggest. In addition, a new recommendation has been added to the section on attitudes to pain and pain relief to highlight that pain is an individual experience, as you suggest.
National Childbirth Trust	Guideline	026	021	We are pleased to see Sterile water added as an option for women with back pain.	Thank you for your comment.
National Childbirth Trust	Guideline	026	024 - 026	Amend *"an initial stinging sensation"* to *"an initial strong stinging sensation"*, to prevent women feeling they had been misled about the severity of the pain.	Thank you for your comment. As pain is such a subjective feeling we have not added this level of detail and the committee agreed that warning women about the stinging sensation was adequate.
National Childbirth Trust	Guideline	027	019	We are pleased to see Remifentanil as an additional option.	Thank you for your comment.

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National Childbirth Trust	Guideline	030	006	Alfirevic et al, 2017 state *"continuous CTG was associated with an increase in caesarean sections and instrumental vaginal births"*. We feel this needs to be balanced against any effect on the baby, and perhaps suggest intermittent auscultation could be better. We have also added a note on rationale p87 11-12.	Thank you for your comment. The recommendation has been amended to state that CTG is only needed if there are other risk factors.
National Childbirth Trust	Guideline	035	001 - 002	We are pleased to see reference to reviewing the woman's labour at a place of her choosing.	Thank you for your comment.
National Childbirth Trust	Guideline	035	019	Options should include "*do nothing".* This is not the same as expectant management, which requires regular visits to a hospital setting.	Thank you for your comment. Regular hospital visits are offered to monitor fetal heart rate every 24 hours but women could choose to decline this monitoring. However, the committee agreed that due to the evidence for increased risk of neonatal infection it would not be appropriate for NICE to advise 'do nothing'.
National Childbirth Trust	Guideline	035	020	*"as soon as possible"* should include a discussion about current availability of the obstetric unit, and factors which may affect the timing of the proposed induction	Thank you for your comment. The phrase 'as soon as possible' was used (instead of 'immediately') as allows for there to be some flexibility in timing depending on practical factors.
National Childbirth Trust	Guideline	035	025	Amend to *"offer induction or further expectant management"*	Thank you for your comment. The committee agreed that induction should be offered after 24 hours. However, the next recommendation (1.7.8) provides advice on the scenario where women choose further expectant management.

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National Childbirth Trust	Guideline	040	001 - 007	We suggest adding: "Inform the woman that she can decline a VE or ask for it to stop at any point Offer to provide the VE in the position she finds most comfortable "If the woman expresses distress or asks you to stop, then stop"	Thank you for your comment. We have amended the recommendation to include that the women can decline or halt the vaginal examination. The position has not been added as the committee agreed that this would need to be agreed with the woman at the time, as the position may need to be a clinical decision depending on the exact reason for the examination.
National Childbirth Trust	Guideline	042	001 - 004	We are pleased to see that fetal monitoring in labour has been separated into its own guideline.	Thank you for your comment.
National Childbirth Trust	Guideline	044	021	We suggest amending to *"If there are any concerns over the woman's ability to pass urine, explain to her the benefit of inserting a catheter. If she consents, insert a catheter"*.	Thank you for your comment. The wording of this recommendation has been amended to make it clear that the insertion of a catheter should be offered. No care or interventions can be carried out without a woman's consent so it is not necessary to state this in every recommendation
National Childbirth Trust	Guideline	048	021 - 024	Suggest adding to this para "*Remind the woman that she can be helped to move into a more upright position which may feel more comfortable and work with her body to aid progress"*	Thank you for your comment. The page/line number you have referred to relates to recommendations about oxytocin so we have not been able to make the change you suggest.
National Childbirth Trust	Guideline	048	021 - 024	Suggest adding to this para *"Explain to the woman that intravenous fluids may be needed if she is dehydrated"*	Thank you for your comment. The recommendation already state that intravenous fluids may be needed if the woman is dehydrated, and the decision to start fluids

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					would require a discussion with the woman to obtain her consent, so this recommendation has not been amended.
National Childbirth Trust	Guideline	048	021 - 024	Suggest adding to this para "Explain to her that she can tell the midwife if she finds the experience distressing, and the dose can be reduced or stopped"	Thank you for your comment. The advice that a woman can ask for oxytocin to be stopped is already included in recommendation 1.8.45 so it has not been repeated here.
National Childbirth Trust	Guideline	048	025 - 027	Suggest adding *"Ensure the dose used is appropriate to the woman's size"*	Thank you for your comment. This change has not been made as the committee agreed the starting dose of oxytocin would be the same for all women, and then it would be titrated to lead to the appropriate rate of contractions, not according to the woman's size.
National Childbirth Trust	Guideline	049	002	Suggest amending to: *"more frequently than 4 in 10 minutes, or if the woman is distressed, reduce or stop the oxytocin until the woman is having 4 or fewer contractions in 10 minutes"*	Thank you for your comment. The advice that a woman can ask for oxytocin to be stopped is already included in recommendation 1.8.45 so it has not been repeated here.
National Childbirth Trust	Guideline	051	022 - 023	Either add to this point, or insert another point, which mentions the benefits of upright positions and keeping mobile as they are the same for women with or without an epidural (as cited on p52, l1-3). "Upright positions and keeping mobile may be beneficial (as they may reduce fetal heart rate abnormalities, episiotomy rates and improve her birthing experience). [2023]"	Thank you for your comment. The committee reviewed the evidence for position for birth for the 2 separate groups of women - those with an epidural and those without. Therefore the benefits stated in the recommendation for women without an epidural were specific to those women and cannot be extrapolated to women with an epidural.

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National Childbirth Trust	Guideline	052	001 - 003	The benefits cited here are also true for women with an epidural in place, so should also appear there.	Thank you for your comment. The committee reviewed the evidence for position for birth for the 2 separate groups of women - those with an epidural and those without. Therefore the benefits stated in the recommendation for women without an epidural were specific to those women and cannot be extrapolated to women with an epidural.
National Childbirth Trust	Guideline	052	005	We would like to see some acknowledgement that the woman may have her own ideas about how she plans to push, and this should be ascertained before advising her. We suggest: "Ask the woman if she would like encouragement to push If so, would she prefer quiet reassurance or active cheerleading Support the woman to change position to see if that helps move into active second stage, and helps her feel more stable and stronger before pushing" We suspect place of birth, her position, and movement are important factors in the woman feeling able to push spontaneously and would like to see this included in future research (we have added a note to p80).	Thank you for your comment. All the recommendations on pushing provide advice to women on the evidence for different techniques so, exactly as you suggest, the woman can make her own decision about how she wishes to push. The final recommendation in this section already covers strategies such as support, encouragement and changing position, so this has not been amended.

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National Childbirth Trust	Guideline	052	007	We are surprised to see reference to directed pushing, particularly with closed glottis, which we believe RCM has previously stated was not recommended.	Thank you for your comment. This recommendation does not advise directed pushing with a closed glottis.
National Childbirth Trust	Guideline	052	008 - 009	While we concede that the committee may only have evidence for multiparous women, we query what mechanism would mean pushing while exhaling would work for multiparous and not nulliparous women. Or indeed for women without an epidural and not women with an epidural. Suggest amending to "Pushing while exhaling may shorten the active second stage of labour"	Thank you for your comment. The evidence for this particular benefit (shortening the active second stage) was only available for multiparous women so the committee did not agree to extrapolate it to nulliparous women.
National Childbirth Trust	Guideline	052	013 - 017	Suggest adding "Pushing while exhaling may shorten the active second stage of labour"	Thank you for your comment. This has been amended to 'directed pushing whilst exhaling..' in line with the evidence.
National Childbirth Trust	Guideline	052	014 - 015	Suggest amending to *"reduce the chance of having caesarean birth"*, as there is no rationale or evidence for spontaneous pushing causing caesarean birth, merely an association which could be due to other factors. The use of the word *"need"* implies both causation and that no other factors were involved in the decision.	Thank you for your comment. 'Needing' has been changed to 'having' as you suggest.
National Childbirth Trust	Guideline	052	016 - 017	While delaying is evidenced for these items, it should be clear to the woman that she should not restrain from pushing if she feels the	Thank you for your comment. This recommendation relates to women with an epidural so the committee considered it

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				urge. Suggest adding: "If the woman is feeling the urge to push, then she should not restrain, or be restrained, from pushing"	unlikely that women would experience the urge to push, so they did not make this change.
National Childbirth Trust	Guideline	052	018 - 022	Suggest adding "Pushing while exhaling may shorten the active second stage of labour"	Thank you for your comment. The evidence upon which this recommendation was based did not state if the pushing was with open or closed glottis so this addition has not been made.
National Childbirth Trust	Guideline	052	019 - 020	While delaying is evidenced for these items, it should be clear to the woman that she should not restrain from pushing if she feels the urge. Suggest adding: "If the woman is feeling the urge to push, then she should not restrain, or be restrained, from pushing"	Thank you for your comment. This recommendation relates to women with an epidural so the committee considered it unlikely that women would experience the urge to push, so they did not make this change.
National Childbirth Trust	Guideline	052	021 - 022	While delaying is evidenced for these items, it should be clear to the woman that she should not restrain from pushing if she feels the urge. Suggest adding: "If the woman is feeling the urge to push, then she should not restrain, or be restrained, from pushing"	Thank you for your comment. This recommendation relates to women with an epidural so the committee considered it unlikely that women would experience the urge to push, so they did not make this change.
National Childbirth Trust	Guideline	053	004 - 006	We applaud the addition of this point.	Thank you for your comment.

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National Childbirth Trust	Guideline	053	004 - 017	We suggest adding *"If the woman wishes to use a mirror showing the perineum to help her visualise her pushing efforts, support her in her choice"*	Thank you for your comment. The committee agree that some women may wish to use a mirror but did not agree that this level of detail needed to be included as a recommendation.
National Childbirth Trust	Guideline	061	001	We would argue that duration of third stage is not a useful metric to share with women, as they will be spending the first hour or so with their baby anyway. Including it gives a false impression that their time might be better spent doing something else, or that there is always urgency in the birth of the placenta.	Thank you for your comment. The sections on risks and benefits of active and physiological management has been amended so the duration of the third stage is no longer included in the recommendations.
National Childbirth Trust	Guideline	061	019	We applaud this amendment	Thank you for your comment.
National Childbirth Trust	Guideline	061	023 - 024	We suggest that a decision-making graphic is provided, illustrating the incidence of PPH (at >500ml or <1000ml) for each uterotonic and none per 1000 women. This should also include incidence of nausea and vomiting, and impact on breastfeeding, as well as the contraindications mentioned p62 line 5-7. These discussions should take place during pregnancy and be confirmed in labour. Therefore, we suggest amending to: "For a woman who is having a vaginal birth and has chosen to have an active third stage, discuss the choice of uterotonic for active	Thank you for your comment. The choice of uterotonic agent for women having a vaginal birth was based on a combination of both clinical and cost-effectiveness evidence, as well as consideration of other factors such as route of administration, risk of PPH, side-effects and contra-indications so a decision-making graphic would be very complex. However, we have passed your comment to the NICE implementation team when relevant support activity is being planned.

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				management, or confirm her decision made during pregnancy"	
National Childbirth Trust	Guideline	062	013	We query the value of administering the uterotonic with the anterior shoulder, which has no rationale in the evidence provided.	Thank you for your comment. The committee have removed this information about the anterior shoulder as you suggest.
National Childbirth Trust	Guideline	067	009	Where more than one option appears, if these treatments are alternatives and are not to be administered together we suggest the table clearly states that. For example, row 1 column two *"Oxytocin 5 units... OR Oxytocin infusion..."*	Thank you for your comment. 'Or' has been added between options in the same column as you suggest.
National Childbirth Trust	Guideline	071	001	We welcome this addition	Thank you for your comment.
National Childbirth Trust	Guideline	080	007	We would like to see the following added to future recommendations for research: Impact of planned place of birth on the agency of carers to support the woman as they and she wish Impact of local maternity management style on the agency of carers to support the woman as they and she wish Impact on labour dystocia of being supported to change position in labour as desired (i.e., not adopting a static position) Impact on labour dystocia of optimising pelvic capacity using biomechanics in pregnancy and / or during labour	Thank you for your comment. The committee can only make research recommendations on topics for which a search for evidence has been carried out, and for which no evidence or inadequate evidence has been found. Most of these topics were not included in the scope of this update and so no search for evidence has been carried out, or some evidence was found (for example, pushing with open and closed glottis).

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				How are outcomes in women with higher BMI affected by a) weathering due to ethnicity, b) socio-economic disadvantage, c) care attitudes in pregnancy and labour Use and impact on duration of second stage of active labour, maternal morbidity, and infant morbidity, of open and closed glottis pushing as selected by women who have had both explained to them.	
National Childbirth Trust	Guideline	084	030	*"As the increased risks were seen in women across a variety of different planned places of birth (home, freestanding and alongside midwifery-led units, and obstetric units) the committee were unable to determine if the risks were related solely to increased BMI or were affected by the planned place of birth". Yet the draft guideline indicates that BMI of 25+ should inform decisions about place of birth (p9, lines 8-11).* *We query what mechanism would mean that a planned place of birth could affect any risk other than a longer transfer time.*	Thank you for your comment. The recommendations on place of birth by BMI and the recommendations on the risk of BMI above a healthy weight have now been amended, and so the rationale has been amended to clarify this sentence.
National Childbirth Trust	Guideline	085	004 - 006	It is not clear how directing healthcare professionals and women to focus on *"risks"* will increase decisions to birth outside the obstetric unit. We would expect to see the exact opposite and feel this should be	Thank you for your comment. This impact statement has been amended to clarify that these recommendations make it more likely that women at lower BMIs will choose to give birth at home or in a midwifery unit. We note

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				included in *'how the recommendation might affect practice'*. We would also point out that the option to birth at home or in a midwifery-led unit is restricted by an inequitable availability of those services.	your comment about the lack of availability of these services in some areas, but an earlier recommendation advises commissioners that all places of birth should be available.
National Childbirth Trust	Guideline	087	011 - 012	We note that the committee defined the appropriate monitoring and safety procedures, rather than this decision resulting from the evidence review. Due to the implications of CTG monitoring, (Alfirevic et al, 2017; the work of Dr Kirsten Small) we would encourage a thorough investigation of evidence about monitoring needs, including potential implications and feasibility in practice.	Thank you for your comment. The evidence provided details of the potential adverse effects of remifentanil and the committee used this to define the monitoring, in order to ensure these effects were detected early if they arose. The committee did not expect to find, for example, evidence comparing women on remifentanil with monitoring, compared to those with no monitoring. However, we appreciate that the implementation of the recommendations on remifentanil PCA may need an assessment of feasibility and therefore will be considered by NICE where relevant support activity is being planned.
NHS England	Guideline	General	General	We strongly suggest including reference to the importance of Communication: Communicate with and try to understand the person you are caring for. Check with the person themselves, their family member or carer or their hospital or communication passport for the best way to achieve this. Use simple, clear language, avoiding medical terms and 'jargon' wherever possible. Some	Thank you for your comment. The points you have raised are now covered in existing and new recommendations in the sections of the guideline on antenatal education, communication, and care throughout labour.

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				people may be non-verbal and unable to tell you how they feel. Pictures may be a useful way of communicating with some people, but not all. People may not be able to articulate their concerns, feelings and specific reasons for their request.	
NHS England	Guideline	General	General	We strongly suggest clinical staff pay attention to healthcare passports: Some people with a learning disability and some autistic people may have a healthcare passport giving information about the person and their health needs, preferred method of communication and other preferences. Ask the person or their accompanying carer if they have one of these. We strongly suggest where there is reference to information and decision making, that all information is available in accessible format. This may include but is not limited to easy read and plain English versions of written information.	Thank you for your comment. The points you have raised are now covered in existing and new recommendations in the sections of the guideline on antenatal education, communication, and care throughout labour.
NHS England	Guideline	General	General	We strongly suggest reference to making reasonable adjustments: This is a legal requirement as stated in the Equality Act 2010 and is important to help you make the right diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline, and this would include adjustments relating to communication needs and assessing pain.

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				adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. This is an importance consideration in care planning and birth choice considerations. We strongly suggest consideration for existing multidisciplinary input into the care of the person. Consideration should also be given to the role of an organisation's learning disability team or liaison nurse on issues of communication, reasonable adjustments, pain assessment etc. Where an Acute Liaison Nurse is not available, we strongly suggest liaising with the local Community learning disability team.	
NHS England	Guideline	General	General	Where there is reference to pain relief, we strongly suggest making reference to clinical staff being aware of diagnostic overshadowing: This occurs when the symptoms of physical ill health are mistakenly either attributed to a mental health or behavioural problem or considered inherent to the person's learning disability or autism diagnosis. We strongly suggest adequate pain relief is planned for.	Thank you for your comment. An additional recommendation has been added to the section on attitudes to pain about taking into account different experiences of pain and how it may be expressed, particularly in people with neurodiverse conditions, to help avoid diagnostic overshadowing.

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NHS England	Guideline	007	012	We strongly suggest where there is reference to information and decision making, that all information is available in accessible format. This may include but is not limited to easy read and plain English versions of written information. We strongly suggest that where links are provided within the document, accessible versions of the information signposted too are also made available.	Thank you for your comment. All NHS services are expected to provide information in an accessible format and this is described in the NICE guideline on patient experience in adult NHS services (CG138), which is cross-referenced from this guideline. This detail is therefore not repeated in all individual NICE guidelines.
NHS England	Guideline	007	013	1.3.2 Should this say 'NHS England website' rather than 'NHS website'? I can't access the hyperlink so I'm not sure what this links to either.	Thank you for your comment. This link is to the patient-facing NHS website (www.nhs.uk). The links to the website did not work in the pdf consultation document but will work on the live version of the final guideline.
NHS England	Guideline	009	008	Where tables are referenced for use in discussion, we strongly suggest where there is reference to this information to aid decision making, that all information is available in accessible format and presented in a way that is easy to understand for people who may encounter challenges with communication of complex information. This may include but is not limited to easy read and plain English versions of written information.	Thank you for your comment. All tables included in NICE guidelines are designed to be as accessible as possible, with no merged cells so that screen readers can read them as plain English. It is not usually possible to produce easy read versions of all information but this request will be passed to the NICE team for implementation support for consideration.
NHS England	Guideline	010	002	Recommendations The lack of data in the middle two cohorts is	Thank you for your comment. We have amended the summary tables to clarify

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				unfortunate since an assumption could be made about a linear relationship that seems likely to be ill-founded on the basis of two figures. Would it be helpful to add a foot note to explain that no conclusion can be drawn against those cohorts marked as "no data". Whilst obvious to those familiar with such tables, it may not be to the wider public audience. (Unless any further information could be added to the table such as risk for women of all cohorts.)	comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail.
NHS England	Guideline	011	003	Recommendations The lack of data in the middle two cohorts is unfortunate since an assumption could be made about a linear relationship that seems likely to be ill-founded on the basis of two figures. Would it be helpful to add a foot note to explain that no conclusion can be drawn against those cohorts marked as "no data". Whilst obvious to those familiar with such tables, it may not be to the wider public audience. (Unless any further information could be added to the table such as risk for women of all cohorts.)	Thank you for your comment. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail.
NHS England	Guideline	017	Table 11 line 3	**Other factors indicating increased risk and suggesting planned birth at an obstetric unit** In the care bundle (element 5) we suggest	Thank you for your comment. The committee agreed that previous preterm birth did not need to be included in this list, as women with a previous preterm birth would be considered as

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				using the risk assessment and management tool for pregnant women at risk of preterm birth and include the following : Previous preterm birth or mid-trimester loss (16 to 34 weeks gestation ; Previous preterm prelabour rupture of membranes <34/40. ; Previous use of cervical cerclage ; Known uterine variant (i.e., unicornuate, bicornuate uterus or uterine septum) Intrauterine adhesions (Ashermann's syndrome). History of trachelectomy (for cervical cancer). Therefore, should previous pre term birth be included in the list?	high risk, would not be in the scope of this guideline and would follow a separate care pathway, but that if women passed 37 weeks (the scope of this guideline) then they would revert to a the same considerations as women without a previous preterm birth, for planning their place of birth.
NHS England	Guideline	021	010	We welcomed the direct reference to people with a learning disability in relation to information to support shared decision making. We strongly suggest this line is expanded to include autistic people. We strongly suggest this section signposts to the availability and presence of healthcare passports (see general comment #2).	Thank you for your comment. Autism and healthcare passports have been added to the examples in this recommendation.
NHS England	Guideline	024	008	We strongly suggest this section is expanded to include a direct reference to making reasonable adjustments – see general comment #3. We strongly suggest this section includes reference to the consideration for existing pathways to support people with a learning	Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline.

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				disability and autistic people for example, desensitisation programmes to support successful intervention.	
NHS England	Guideline	025	001	Consider including if the woman is alone make sure the named birth companion/ partner is informed of the transfer via telephone	Thank you for your comment. The recommendations already state that the decision to transfer care should be discussed with the woman and her birth companions so further detail about this has not been added.
NHS England	Guideline	028	020	The clarifying comments about the likelihood of a non-event in all the tables are very helpful to ensure that there is balance within discussions about risk.	Thank you for your comment.
NHS England	Guideline	038	001	1.8.4 A 'care plan' is referred to as a 'plan of care,' and both terms are used interchangeably within the document. I think it would be better to be consistent and use 'care plan' throughout.	Thank you for your comment. The meanings of the 2 phrases are not identical: a care plan is an agreed course of care or treatment (written or verbal), whereas in this context the phrase 'agree a plan of care' is an active phrase suggesting that a new plan is made. This has not therefore been changed.
NHS England	Guideline	066	001	SSRI/SNRI use comes up frequently in pre-pregnancy planning and antenatal discussions in primary care, women could worry that they were not informed of this risk early enough in their pregnancy journey so wonder whether a comment to consider relative risk as part of an earlier discussion should be made.	Thank you for your comment. The committee agreed that the use of SSRI/SNRI antidepressants would ideally be discussed as part of antenatal care, but this would also apply to any medication a woman was taking at the beginning of pregnancy. However, as the MHRA advice about SSRI/SNRIs and postpartum haemorrhage (PPH) was specific to the last month before birth the committee

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					agreed it was useful to raise in the section on risk factors for PPH.
NHS England	Guideline	090	General	Interventions to reduce perineal trauma The section on 'Interventions to reduce perineal trauma' goes at odds with the best practice in the RCOG's OASI Care Bundle and does not pay regard with the evidence generated by associated studies. The Maternity Programme at NHSE requests that NICE pays regard to this evidence as far as possible. This comment also relates to Evidence review I.	Thank you for your comment. The committee reviewed the evidence for hand position again, and as it was low quality they agreed it was insufficient to provide guidance on the best hand position and so have removed this recommendation and instead just made a research recommendation. The committee recognised that the other aspects of the OASI care bundle include guidance on episiotomy angles and rectal examination, and that these aspects were also covered in the intrapartum care guideline so they made minor editorial amendments to the recommendations on rectal examination in light of this.
NHS Kent and Medway ICB	Guideline	006	009	How will trusts enable access to freestanding MLUs if not currently part of estates? Will the LMNS's have agreements on cross-Trust care.	Thank you for your comment. The guideline provides recommendations to advise on the best possible clinical care, and this should include the option of birth in a freestanding midwifery unit for women who wish to have this. There may be situations where operational aspects need to be taken into consideration when implementing these recommendations in individual cases but the committee agreed it was not within the remit of the guideline to provide advice on operational issues, and that other options such as

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					partnering with adjacent freestanding units may need to be considered locally.
NHS Kent and Medway ICB	Guideline	006	014	Good to see auditing of transfer times to give women and birthing people informed decision making on place of birth.	Thank you for your comment.
NHS Kent and Medway ICB	Guideline	007	022 & 025	Some find the wording " particularly suitable" when discussing homebirth for birth multips and primps a bit coercive and that it should be a fully informed decision.	Thank you for your comment. The committee changed this wording to highlight the rate of interventions rather than suggesting a place of birth may be particularly suitable.
NHS Kent and Medway ICB	Guideline	015	009	With above, do these contradict each other? One says no increased risk for baby and the other says and increase by 4 per 1000 for homebirth.	Thank you for your comment. Table 9 (now Table 5) showing outcomes for the baby shows that the rates of babies with serious medical problems are the same (5 per 1,000 births) whether birth takes place in a freestanding or alongside midwifery unit or obstetric unit, but is 9 per 1,000 when birth takes place at home, so these two points do not contradict each other.
NHS Kent and Medway ICB	Guideline	016	013	With below, do these contradict each other? One says no increased risk for baby and the other says and increase by 4 per 1000 for homebirth.	Thank you for your comment. Table 9 (now Table 5) showing outcomes for the baby shows that the rates of babies with serious medical problems are the same (5 per 1,000 births) whether birth takes place in a freestanding or alongside midwifery unit or obstetric unit, but is 9 per 1,000 when birth takes place at home, so these two points do not contradict each other.
NHS Kent and Medway ICB	Guideline	022	024	This change in practice to include the woman in bedside handovers is appreciated.	Thank you for your comment

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NHS Kent and Medway ICB	Guideline	025	006	If performing IA on a transfer is this for reassurance for the woman/ birthing person? However, if due to foetal heart concerns/ prolonged second stage etc may this increase anxiety and intervention if not going to be possible within the transfer? Every circumstance is different and maybe needs to be tailored to the situation.	Thank you for your comment. The advice to carry out intermittent auscultation was added to the guideline as the committee were aware of situations where women were not monitored during transfer and so deterioration in the baby's condition was not identified. Although management may not be possible during transfer it may inform the urgency of action required on arrival at the obstetric unit.
NHS Kent and Medway ICB	Guideline	025	030	With current delays in IOL do we need to stipulate a timeframe to help categorise urgency?	Thank you for your comment. We are not sure what your comment relates to as page 25, line 30 does not exist.
NHS Kent and Medway ICB	Guideline	037	009	The 4cm rule may deter from a holistic review of the situation and some women regularly contracting < 4cm will miss out of appropriate Foetal monitoring/ labour care.	Thank you for your comment. The committee agree that that as they had not reviewed the evidence they were not aware of any reason to amend the dilatation from 4cm.
NHS Kent and Medway ICB	Guideline	040	014	The observation criteria are very generalised and not individualised for the woman. For HR and BP should we not be assessing the woman's baseline and assessing trends with MEOWS.	Thank you for your comment. The committee were aware that MEOWS charts were being rolled out and that when this was the case then the MEOWS chart could be used to observe trends, but did not add to the recommendations as a national MEOWS chart has not yet been agreed.
NHS Kent and Medway ICB	Guideline	049	005	"Pathological CTG" is a term not used by many Obstetric units in the UK now. Perhaps this should be worded with a more inclusive term for all CTG interpretation methods.	Thank you for your comment. 'Pathological CTG' is the terminology used in the NICE guideline on fetal monitoring in labour so has been used here for consistency.

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NHS Kent and Medway ICB	Guideline	058	022	The word "Consider" could be replaced with "Offer" as consider means an instrumental even in the presence of foetal distress may not be offered. More general comments: The guidance uses the term women to mean everyone who is pregnant. This seems to be very exclusionary and additive language representative of the birthing population should be considered. Trusts use the NICE guidance as an example of why they don't have to use additive language and can just use the term women to cover everyone. Communication:- the guidance should state a literacy age range / appropriate level for communications so they are easily read and understood by the majority of the population. TENS machines are no longer recommended or given by the NHS. Evidence from women says that they help with labour pain and the evidence is on par with sterile water injections so why the change?	Thank you for your comment. The committee agreed that birth with forceps or ventouse in delayed second stage would have to be offered and so made this change. The new NICE style guide provides advice on additive language to be more inclusive, but this language is not currently being applied retrospectively to all existing guidance. All recommendations in NICE guidelines are written to ensure they are as easy to read and understand as possible, while recognising that they have to convey clear advice to professionals, which may require the use of some technical terms. The evidence for TENS machines was not prioritised for inclusion in this update, but surveillance identified new evidence relating to the use of sterile water injections, so these were prioritised for inclusion.
Nottingham University Hospitals NHS Trust	Evidence Review N Position of baby during	011	038	38 "effectiveness. However, the lack of evidence meat that that the committee did not advise one" Should 'meat' be read as 'means'	Thank you for your comment. This has been amended.

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	cord clamping				
Nottingham University Hospitals NHS Trust	Guideline Title of the guidance			It states "Intrapartum care for healthy women and babies (update)" but only includes term babies. Preterm babies can also be 'healthy'. I would suggest title to be changed to 'term babies'	Thank you for your comment. The committee agreed that leaving the title more open in relation to the age of the babies allowed more flexibility in the use of the guideline. Although the population for the evidence reviews was term babies, there is some overlap in topics such as pain relief which are not covered in the preterm labour and birth guideline and would be applicable to women in full-term or preterm labour.
Obstetric Anaesthetists' Association	Guideline	026	022	Rec 1.6.12 All the evidence that NICE reviewed was graded poor by NICE except for one Turkish midwife study with blinding methodology that was vague which found injections reduced back pain 3 hours after injection. What possible biological plausible explanation is there for benefit with intracutaneous or subcutaneous injections of water in volumes of 0.1 to 0.4mls? Because it is cheap and unlikely to cause harm, is an inadequate justification for a recommendation, especially as NICE does not recommend other similar non-pharmacological therapies such as acupuncture and hypnosis. It appears that	Thank you for your comment. Although the evidence was classified using GRADE as low to moderate quality the committee agreed there was sufficient evidence of benefit to recommend sterile water injections. The use of hypnosis and acupuncture were not prioritised for inclusion in this update as no new evidence for them was identified by surveillance. If new evidence becomes available that suggests they may be of benefit it will be reviewed by surveillance for consideration in part of a future update.

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				NICE is supporting a homeopathic approach to managing pain in labour.	
Obstetric Anaesthetists' Association	Guideline	027	019	Rec 1.6.19 The offer of remifentanil PCA should not necessarily be limited and offered only to those women who do not want epidural analgesia but should be available as an option of labour analgesia for women in obstetric units. The use of specific doses is, perhaps, a little didactic. Many units use smaller doses with many units starting with 20 or 30mcg boluses, only escalating to 40mcg if needed.	Thank you for your comment. This recommendation has been amended to state that remifentanil PCA can be an option for any woman who wants ongoing pain relief.
Obstetric Anaesthetists' Association	Guideline	028	004	Rec 1.6.21 The shared decision making about the use of remifentanil PCA should not be limited to a comparison between remifentanil and intramuscular pethidine but should be in the context of all other alternative modes of labour analgesia which in an obstetric unit should include epidural analgesia. The risk of respiratory arrest with remifentanil PCA should be mentioned.	Thank you for your comment. The protocol for this review only considered the comparison of remifentanil with opioids as the committee agreed that it was this comparison that best reflected its place in therapy, and that it was not intended to be replacement for epidurals which offer local anaesthesia and pain relief. The risk of respiratory depression has been included (measured using respiratory rate, requirement for supplemental oxygen and oxygen saturation less than 94%) but respiratory arrest was not prioritised as an outcome for this review.

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Obstetric Anaesthetists' Association	Guideline	030	004	Rec 1.6.22 The most important point around remifentanil is safety. If the criteria listed in 1.6.22 for safe delivery of remifentanil PCA cannot be met or delivered, then it should not be provided nor used. This should be explicitly stated.	Thank you for your comment. The recommendations make it clear that very close monitoring is required if remifentanil is going to be used, so this additional statement has not been added.
Obstetric Anaesthetists' Association	Guideline	032	010	Rec 1.6.30 To add: 'There must be local guidelines and training available to midwives be able to assess leg weakness for safe decision making on mobilisation'.	Thank you for your comment. The recommendation has been amended to state that this decision must be made by a midwife trained in caring for women with epidurals. The committee did not make the addition about local protocols as this would apply to a large number of recommendations.
Obstetric Anaesthetists' Association	Guideline	033	016	Rec 1.6.40 In this section add "appropriately trained" before "healthcare professionals"	Thank you for your comment. 'Trained' has been added before healthcare professional as you suggest.
Obstetric Anaesthetists' Association	Guideline	051	019	Rec 1.9.5-1.9.6 We note with surprise that the NICE committee were critical of the BUMPES 2017 study which is the largest RCT to date on maternal position in the 2nd stage with labour low-dose epidural analgesia which showed a NNT of 17 to achieve an additional NVD if nulliparous women with labour epidural analgesia adopted the lateral position in 2nd stage of labour with no apparent harm.	Thank you for your comment. The committee noted the statistically significant benefit of the lateral position in the BUMPES study for vaginal birth but noted that the difference did not meet the NICE criteria for minimally important difference. However, the committee agreed to amend this recommendation to make women aware that use of a lateral position may increase the chance of a spontaneous vaginal birth.

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Obstetric Anaesthetists' Association	Guideline	062	008	Rec 1.10.12 Why is cyclizine used as an example of an antiemetic instead of ondansetron, which is more routinely given? The mode of administration of cyclizine is important as rapid intravenous administration can result in its anticholinergic effects (tachycardia, dry mouth, blurred vision) and antihistamine effects (drowsiness) becoming apparent and cause misinterpretation in the context of the third stage of labour with its risk of haemorrhage/hypovolaemia.	Thank you for your comment. Cyclizine is given as an example of an anti-emetic as it is subject to a midwives' exemption to the prescription only medicines regulations and so can be given by a midwife without need for a prescriber's signature.
Obstetric Anaesthetists' Association	Guideline	062	010	Rec 1.10.13 The BNF states that a bolus of intravenous syntocinon should not exceed 5 units. This is because of the potential deleterious cardiodynamic effects of the higher dose of intravenous syntocinon. This reduced initial dose of 5 units should be used if it is given intravenously and this should be explicitly stated.	Thank you for your comment. This has now been corrected to 5 units for intravenous administration.
Obstetric Anaesthetists' Association	Guideline	062	020	Rec 1.10.15 Whilst the NICE guidance elsewhere states that instrumental assisted vaginal delivery is a risk factor of postpartum haemorrhage (1.10.31) there is no acknowledgment of this in the recommendations for management of the third stage. We are aware of local audit	Thank you for your comment. The NMAs were not separated by type of vaginal birth (spontaneous or birth with forceps or ventouse) as the majority of included studies did not specify this level of detail, and those that did specify were a mix of the two types of birth. Given this lack of evidence available to the

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				data that shows that the risk of a postpartum haemorrhage >1500mls with an instrumental delivery is three times greater compared to normal vaginal delivery and two times greater compared to a caesarean delivery. We suggest that NICE considers making a specific recommendation about the third stage management after an instrumental delivery that is similar to that for a caesarean delivery.	committee on risk of postpartum haemorrhage in assisted versus spontaneous vaginal birth, it was not possible to make separate recommendations on which treatments should be used in management of the third stage after birth with forceps or ventouse.
Obstetric Anaesthetists' Association	Table B	101	General	Typographical note As Apgar scores are named after Virginia Apgar and is not an acronym it should not therefore be written in uppercase letters (see column 2).	Thank you for your comment. This has been changed to lowercase.
Oxford Brookes University	Guideline	053	007	Rec 1.9.13 – 'once the presenting part distends the perineum' we recommend that this phrasing be amended to for example 'once pushing has commenced'…. To encompass second stage as for some women, perineal distension may occur minutes before the baby's head is born. The comfort of a warm wet compress may relax her and she might be more likely to gain the demonstrated benefits off perineal compress.	Thank you for your comment. The evidence was based on use when the presenting part leads to distension so the committee did not change this, as pushing may commence much earlier than the compress is needed.
Oxford Brookes University	Guideline	053	008	Rec 1.9.13 - 'A warm compress' we suggest that this read as warm wet compress for clarity.	Thank you for your comment. This has been changed to 'warm wet'.

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Oxford Brookes University	Guideline	053	008 - 009	Rec 1.9.13 For clarity we suggest that these words be added to this sentence …..'and continue this until birth' during and between contractions. We also suggest adding that the compress should cover the perineum and ideally the vulva.	Thank you for your comment. The recommendation already advises that the compress should be used until birth, and the committee agreed that the evidence was for a compress on the perineum so did not add the vulva.
Oxford Brookes University	Guideline	053	009	Rec 1.9.13 'Check the temperature of the compress is comfortable for the woman'. We suggest that adding this to the sentence would offer greater maternal comfort – refreshing the compress regularly in warm water Significant benefits of warm wet compress continue to be found 2019,	Thank you for your comment. The committee agreed that to keep the compress warm it would need to be refreshed in warn water so did not add this to the recommendation.
Oxford Brookes University	Guideline	053	011	Rec 1.9.14 – 'Gentle stretching of the perineum'…. We are concerned that this recommendation in the same sentence as massage gives a mixed message because they are 2 different interventions. There is research showing that massage is associated with a reduction in episiotomy and OASI if undertaken 'during or between pushing time'. Also Systematic review 2 found an episiotomy reduction but no significant reduction in OASI. There is no quality primary research showing that stretching a perineum offers any benefit and be may be painful and unpleasant for the	Thank you for your comment. The recommendation has been amended to take out 'gentle stretching' as the evidence considered was for 'massage'.

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				woman. We suggest therefore suggest this be removed.	
Royal College of Anaesthetists	Guideline	028 - 030		On Remifentanil PCA, it is correct the Respite trial showed it to be preferable to pethidine but that's not really saying much. Of course there should be comparison with epidural analgesia. The most important point about Remi is around safety. A midwife trained in the care of women using Remi should be continuously present to observe RR and SpO2. Just stipulating one to one care is insufficient. Respiratory depression and adverse neonatal consequences have been reported.	Thank you for your comment. The protocol for this review only considered the comparison of remifentanil with opioids as the committee agreed that it was this comparison that best reflected its place in therapy, and that it was not intended to be a replacement for epidurals which offer local anaesthesia and pain relief. The advice that remifentanil should be considered as an option for women who do not want an epidural has been removed from the recommendation. The recommendations already include details about the monitoring that is required for women receiving remifentanil, including respiratory rate and oxygen saturations. The occurrence of respiratory depression is provided in the table, but in the evidence review no adverse neonatal consequences were identified.
Royal College of Anaesthetists	Guideline	030 onwards		"Regional analgesia" section The Cochrane reported a post hoc analysis of data later than 2005 showed no increase in assisted vaginal delivery. The guideline should stipulate do not discontinue epidural analgesia in 2nd stage	Thank you for your comment. The information about evidence that might lead to a change in the recommendations has been passed to the NICE surveillance team who monitor guidelines to ensure that they are up to date, for consideration for a future update.

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Royal College of Anaesthetists	Guideline	030	005	One to one midwifery care is needed but these midwives must also be trained to look after women using remifentanil PCA in the same way that they are trained to look after women who have epidurals	Thank you for your comment. The need for the midwife to be trained in the care of women receiving remifentanil PCA has been added to the recommendation.
Royal College of Anaesthetists	Guideline	031		1.6.25 in table Regarding the information on the risks of epidurals when discussing with the mother; when comparing this to this reminfentanil section 1.6.21, page 28, there is additional information on the risks of the use of remifentanil in this setting and yet the guidelines don't provide similar information for epidurals. Is there a reason for this? Should we also include in this guideline what information to give mothers on the risks of epidurals particularly long term effects of accidental dural puncture, of which the evidence is growing- see attached powerpoint presentation with details of evidence.	Thank you for your comment. The section of the guideline on regional analgesia/epidurals was not included in the scope of this update, and when the current recommendations were made it was not common practice to include tables of risks and benefits. However, as guideline sections are gradually updated it is likely that more and more of these tables will be included.
Royal College of Anaesthetists	Guideline	032		If the anaesthetist is informed every time a woman is unable to SLR in labour they may be inundated with calls. Whilst the woman is in labour - what should they do - deny her further pain relief? What evidence is this based on?	Thank you for your comment. The addition to the guideline about checking that women can do a straight leg raise was based on safety guidelines produced by the Association of Anaesthetists and the Obstetric Anaesthetists Association in 2020. (Yentis et al. Anaesthesia 2020,75,913-919)

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Royal College of Anaesthetists	Guideline	062	010	The BNF states that 5IU of oxytocin should be given if the intravenous route is used and 10IU if the intramuscular route is used	Thank you for your comment. This has now been corrected to 5 units for intravenous administration.
Royal College of Anaesthetists	Guideline	100		1.8.23 in table Fluid balance monitoring - all women in labour should have this	Thank you for your comment. Fluid balance would only need to be assessed in certain circumstances and these are listed directly in the second bullet point of this recommendation.
Royal College of Anaesthetists	Guideline	100		1.6.30 in table Mobilisation; the midwife should be trained to undertake tests of safe mobilisation	Thank you for your comment. This recommendation has been amended to include the fact that it should be caried out by midwives who are trained in caring for women with epidurals.
Royal College of Anaesthetists	Guideline	131		1.8.17 in table We think it should mention the possible danger [eg hyponatraemia esp with oxytocin infusions], as well as lack of benefit of drinking 'more than normal' in labour.	Thank you for your comment. The risk of hyponatremia with oxytocin infusions is addressed in another recommendation, 1.8.47.
Royal College of Anaesthetists	Guideline	132		1.8.18 in table Question the position on women in active labour eating. Only those with really good analgesia want to eat and the need for general anaesthesia cannot be reliably predicted.	Thank you for your comment. The recommendation has been amended to clarify that it is the risk of needing a caesarean birth, not a general anaesthesia, but we agree this may not always be predictable. However, if women wish to eat during a long labour with no imminent risk of caesarean birth then the committee agreed that this recommendation, which has been in the guideline since 2007, should remain.

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Royal College of Anaesthetists	Guideline	135		1.9.5 in table Position in the 2nd stage in labour with an epidural: it appears the results on the BUMPES study are ignored [i.e better outcomes in recumbent opposed to upright group].	Thank you for your comment. The committee noted the statistically significant benefit of the lateral position in the BUMPES study but noted that the difference did not meet the NICE criteria for minimally important difference. However, the committee did agree to amend the recommendation to inform women about the benefits on spontaneous vaginal birth from adopting a lateral position.
Royal College of Anaesthetists	Guideline	163		1.10.35 in table Give supplemental O2 'if needed': It is 'needed' because oxygen carrying capacity is reduced.	Thank you for your comment. The committee changed this recommendation to state that supplemental oxygen should be considered to obtain a target oxygen saturation of 94 to 98%.
Royal College of Midwives	Evidence Review G	General	General	Although the introduction states that the review questions are "what is the most effective position for birth…", the protocol then compares women assuming an upright position with any recumbent position during the second stage of labour. The restriction from "what is the most effective position" to "upright compared with recumbent" is perhaps why the conclusions of the evidence review are so flawed. Recumbent positions includes lying flat on ones back (supine), which is associated with veno-caval compression and fetal compromise, and also include being lateral	Thank you for your comment. The committee decided during the formulation of the review protocol that all positions of birth should be considered in our evidence review. However only 2 studies were identified for review (BUMPES 2017 and Golara 2022) and they have been analysed separately (not pooled) as the positions of birth were defined/classified differently in these studies. BUMPES 2017 included left or right lateral positions in recumbent group specifically excluding lying flat on ones back. The smaller study, Golara 2002. came from a major UK maternity unit with around a 50-year history of research on this specific topic and although not mentioned

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				(lying on ones side) which does not present any risk to the fetus. To conflate both of these positions into the comparison group is inappropriate and will certainly not allow a review to find the most "effective position".	in this publication the committee considered it inconceivable that the recumbent position would include lying flat on the back. Furthermore, this study only studied the passive not active second stage. Accordingly, the committee did not consider that in their review of the evidence they included women lying flat on their back in the comparison recumbent group. The committee's discussion and interpretation of the evidence is detailed in section 'The committee's discussion of the evidence' of the evidence review.
Royal College of Midwives	Evidence Review G	General	General	Given the high proportions of women giving birth spontaneously who experience birth in lithotomy it is surprising that no evidence was found for this intervention. Whether or not the lithotomy position was included in the review this should be stated.	Thank you for your comment. Lithotomy was included in our search; however we did not identify any evidence for this position that met the evidence review inclusion criteria.
Royal College of Midwives	Evidence Review G	General	General	The review's introduction suggests that the group were not in equipoise when reviewing the available evidence. The statement that "the assistance of gravity associated with upright positions is also thought to lead to benefits during labour and birth" is not referenced but indicates committee bias.	Thank you for your comment. This sentence has been removed from the introduction section of the evidence review.

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Royal College of Midwives	Evidence Review G	006	015 & 016	Another fallacy perpetuated in line 15-16 of the introduction is that in women without an epidural "all positions are more likely to be possible" – and while this may be true for being mobile, it is certainly not true when it comes to adherence to any allocated position in a clinical trial. Women with an epidural, who should be completely pain free, are more likely to be able to maintain each allocated position, whereas women without an epidural are more likely to move and become non-adherent.	Thank you for your comment. This comment is included as part of the introduction of the review chapter providing some background information, not as a means of rationalising the evidence. The committee reviewed the evidence on positions of birth separately for women with and without an epidural. The committee's discussion of evidence including non-adherence to interventions in women without an epidural is detailed in the 'The committee's discussion of the evidence' section.
Royal College of Midwives	Evidence Review G	013	006 - 008	**Evidence:** In the BUMPES trial there was clear evidence of a highly statistically significant 6% absolute difference in the chances of having a spontaneous vaginal birth. This cannot be considered to be "no evidence of an important difference". Given that the intervention, lying on one's side, is completely risk free and of no cost to either women or the health service, this conclusion is wrong. https://www.birmingham.ac.uk/research/bctu/trials/womens/bumpes/bumpes-trial.aspx The reason for reaching this conclusion appears to rest on the committee judging the trial to be of low quality. Again, this is	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We have conducted separate analysis for BUMPES 2017 and Golara 2002. There was statistically significant increase in spontaneous vaginal births for nulliparous women who were in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration

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				incorrect. The trial, the single largest trial of maternal position in labour ever conducted, was rigorous in its design and execution. It was peer reviewed prior to funding by the NIHR HTA Programme. It was overseen by an independent Trial Steering Committee and Data Monitoring Committee, and the reports were peer reviewed by the BMJ prior to publication, the NIHR HTA Programme prior to the final report being published, and it was then further per reviewed in order to be awarded the BMJ UK Research Paper of the Year in 2018. It is extremely improbable that all these peer reviewers were wrong and the guideline review group have found substantial flaws which would compromise the validity of the findings where no one else has.	when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour. The committee's discussion and interpretation of the evidence is detailed in section 'The committee's discussion of the evidence' of the evidence review. This guideline review uses the GRADE approach for assessing quality of evidence as detailed in the NICE guidelines manual and the methods chapter for this review. The quality of each outcome is assessed following GRADE processes taking into account risk of bias of the individual studies, the inconsistency, imprecision and indirectness. Each study is assessed for risk of bias. As participants and personnel could not be blinded to intervention allocation in BUMPES 2017, subjective outcomes were downgraded for risk of bias.
Royal College of Midwives	Evidence Review G	016	036 - 042	Evidence: There were specific criticisms in the consultation document which suggest that the BUMPES trial report (both the BMJ paper and the NIHR report) were not read in any	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We

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				detail. The review group stated that the evidence from BUMPES was at risk of bias. They justified this by describing that a proportion of women had their labours induced. And they claimed that the primary outcome of the trial was not adjusted for this hence the results "were downgraded for indirectness". This is false. The authors acknowledged that labour induction may be a confounder and clearly stated the following in the BMJ paper: "We further adjusted the analysis of the primary outcome to investigate the impact of known prognostic factors (age, ethnicity, diagnosis of delay, onset of labour—induced versus spontaneous)", and the results section states: " A clear statistically significant difference (at the 5% level) in the incidence of the primary outcome of spontaneous vaginal birth was found between the groups, with 35.2% (548/1556) of women achieving spontaneous vaginal birth in the upright group compared with 41.1% (632/1537) in the lying down group (adjusted risk ratio 0.86, 95% confidence interval 0.78 to 0.94) (table 3). This represents a 5.9% absolute increase in the chance of spontaneous vaginal birth in the lying down group (number needed to treat 17, 95% confidence interval 11 to 40). This	have conducted separate analysis for BUMPES 2017 and Golara 2002. There was statistically significant increase in spontaneous vaginal births for nulliparous women who were in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour. The committee's discussion and interpretation of the evidence is detailed in section 'The committee's discussion of the evidence' of the evidence review. Thank you for highlighting that BUMPES 2017 was downgraded for indirectness. This has been amended to not to downgrade it for indirectness in the report and quality rating has

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				result was unchanged when adjusting for age, ethnicity, diagnosis of delay, and the nature of the onset of labour (adjusted risk ratio 0.86, 95% confidence interval 0.79 to 0.94)." https://www.birmingham.ac.uk/research/bctu/trials/womens/bumpes/bumpes-trial.aspx This barely detectable difference between the two analyses demonstrates that labour induction is not a confounder of the relationship between the positions that we compared in the BUMPES trial.	been changed accordingly. This guideline review uses the GRADE approach for assessing quality of evidence as detailed in the NICE guidelines manual and the methods chapter for this review. Each study is assessed for risk of bias. As participants and personnel could not be blinded to intervention allocation in BUMPES 2017, subjective outcomes were downgraded for risk of bias. The quality of each outcome is assessed following GRADE processes taking into account risk of bias of the individual studies, the inconsistency, imprecision and indirectness.
Royal College of Midwives	Evidence Review G	017	021 - 030	The group also states that the "actual adopted positions for birth in the two groups were not reported". Again, this is false. This was reported, albeit briefly, in the BMJ paper, but was reported extensively in the HTA report (which was found by the reviews search), suggesting that the report, which contains these additional data, was not read.	Thank you for your comment. We have now noted the actual positions of birth in BUMPES 2017 in our evidence report. We have also amended relevant sections in 'The committee's discussion of the evidence' to reflect this.
Royal College of Midwives	Evidence Review G	017	038 - 040	A general point about this section on page 17 of the evidence review section is the phrase 'in their experience' which appears to be in relation to the committee's deliberations. This may be important when there is little available evidence. However, when there is	Thank you for your comment. Based on the feedback during the consultation process we have now re-analysed the evidence for birth positions in women with an epidural in situ. We have conducted separate analysis for BUMPES 2017 and Golara 2002. labour

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				high quality and clear evidence that a lateral position is associated with an important and meaningful difference to women in labour, this phrase is inappropriate and it superseded by findings from quality research.	(BUMPES 2017). There was statistically significant increase in spontaneous vaginal births for nulliparous women who were in recumbent positions compared to upright positions during the second stage of labour (BUMPES 2017). However, the effect estimate provided no important difference with respect to the minimally important differences used to interpret the evidence. But the committee agreed women should be informed of this result so they could take this into consideration when deciding on their position of birth. The committee were aware that women with an epidural in situ may need more assistance to mobilise and find a comfortable position. Hence based on the evidence and their knowledge and experience, they agreed that women may choose to lie on their side but could adopt a position which was comfortable for them during the second stage of labour.
Royal College of Midwives	Evidence Review I	006	019 Table 1	Episiotomy is listed as a critical outcome which has potentially introduced bias into the evidence review. We support the recommendation to not perform a routine episiotomy in spontaneous vaginal birth (Guideline page 53 line 20) or routinely in vaginal birth after a previous third or fourth degree tear (Guideline page 54 line 4). Furthermore an episiotomy is recommended	Thank you for your comment. The protocols for the evidence reviews are agreed in advance of the review and when designing the protocol for this review the committee agreed that, when looking at less invasive perineal interventions, it would be useful to know if they reduced the risk of more invasive perineal interventions such as episiotomy. So, in this context, although episiotomy is an intervention,

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				when there is a clinical need (Guideline, page 24, line 24) therefore it is clear that this is considered a necessary intervention to prevent serious trauma (amongst other indications). We recommend Episiotomy be recategorized in this PICO table as an intervention.	the committee included it as an outcome. However, you are correct that in some cases carrying out an episiotomy could be beneficial if it prevented a serious tear, but the reporting of the evidence did not allow this level of detail to be determined. We will note your suggestions for consideration in future updates of the guideline.
Royal College of Midwives	Evidence Review I	007	009	It is concerning to note that the three RCTs used to support these recommendations, had differing definitions and approaches to the hands on/hands off/hands poised across the studies. This makes the drawing of conclusions across the three studies limited. As concerning is that NICE has recognised the study limitations by grading their quality as of low to very low quality, but has continued to use their findings to base these recommendations on.	Thank you for your comment. The evidence that the hands on/hands poised technique recommendation was based on has been revisited by the committee and in the light of the quality ratings of very low to low quality this recommendation has been removed.
Royal College of Midwives	Evidence Review I	007	Table 1	Table 1 omits to mention faecal incontinence, using only urinary incontinence in the first year after birth as an important outcome. Faecal incontinence is, arguably one of the most serious sequalae of severe perineal trauma, having a greater impact on the wellbeing of the woman.	Thank you for your comment. Thank you for highlighting faecal incontinence as an outcome of importance. The outcome of faecal incontinence in the first year after birth has now been added into the review as an important outcome alongside urinary incontinence, although no differences were found between any of the comparisons for

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					which this outcome was available so it did not lead to any changes in the recommendations.
Royal College of Midwives	Evidence Review I	011	024	With regards perineal massage in the second stage of labour – women's experiences of labour and birth has not been explored as to if this is an acceptable intervention. With little data to draw robust conclusions on, it should be considered if recommending perineal massage in the second stage is appropriately supported.	Thank you for your comment. Women's experience of labour and birth was included in the protocol as an important outcome but has not been reported for perineal massage as there was no evidence available from the included studies for this outcome. The committee noted that perineal massage is a simple procedure, however some women may find it invasive to have it done during labour whilst experiencing contractions and so the recommendation has been amended to state this should only be used as a technique if acceptable to the woman. The committee recommend perineal massage as an alternative to a warm compress only if women prefer it. This is described in the committee's discussion of the evidence.
Royal College of Midwives	Evidence Review I	012	011 - 015	The qualitative evaluation of the OASI1 project (2016-18) sought to understand women's experiences of labour and birth, including their experiences of 'hands on' support. Nineteen women were interviewed, with their feedback providing valuable insight. The OASI2 study (2021-23) has sought to expand upon in its evaluation of women's experiences with a survey of ca. 1200 women	Thank you for your comment and for informing us about this evaluation of the OASI project. Details of this study have been passed to the NICE surveillance team who monitor guidelines to ensure that they are up to date.

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				for the same purpose. The OASI2 evaluation is currently underway with publication expected in late 2023. Bidwell P, et al. Women's experiences of the OASI Care Bundle; a package of care to reduce severe perineal trauma (2021)	
Royal College of Midwives	Evidence Review I	015	005 - 010	During its development in 2014, the RCOG and RCM did not include warm compresses as one of the components of the OASI Care Bundle as at the time there existed wide variation in practice, whereas the care bundle aimed to introduce a standardised set of practices that could be applied consistently. We fully acknowledge the evidence that warm compresses can reduce the risk of severe perineal trauma and encourage their use by midwives and obstetricians independently of or alongside the OASI Care Bundle. The OASI2 study (2021-23) has promoted additional perineal care techniques such as warm compresses and antenatal perineal massage in its antenatal discussion guide for women, conference talks and teaching materials for clinicians as part of a range of practices women can choose as part of their birth plan to reduce third- and fourth-degree tears.	Thank you for your comment and your support for the recommendation for warm compresses. The evidence that the hands / on hands poised technique recommendation was based on has been revisited by the committee and in the light of the quality ratings of very low to low quality this recommendation has been removed. The committee recognised that the other aspects of the OASI care bundle include guidance on episiotomy angles and rectal examination, and that these aspects were also covered in the intrapartum care guideline so they made minor editorial amendments to the recommendations on rectal examination.

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				We would contend that interventions such as 'hands on' (manual perineal protection) should not be considered in isolation but always as part of a combination of interventions that can be implemented together because the causes of third- and fourth-degree tears are complex. The US Institute for Healthcare Improvement (IHI) defines a care bundle as a small set of evidence-based practices that, when performed collectively and reliably, will likely result in better outcomes than when implemented individually. The development and implementation of the OASI Care Bundle was supported by the two principal national professional bodies representing maternity professionals and encouraged multidisciplinary teams to work together. The intervention was multifaceted and informed by a detailed theory of change, with women involved in all stages of the project to ensure that the implementation of the care bundle supported women's choice of birth position and the importance of communication during labour. The project team evaluated the OASI Care Bundle for clinical effectiveness as well as barriers and enablers to uptake in 16	

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				participating units in England, Scotland and Wales (OASI1 project). OASI1 had a stepped-wedge design and was powered to detect changes in rates of third- and fourth-degree tears (the primary outcome) following the implementation of the OASI Care Bundle. The clinical results, published in BJOG, compared almost 28,000 singleton vaginal births that took place before implementation of the care bundle with 27,000 singleton vaginal births that took place after. OASI rates (third- and fourth-degree tears) in the implementation period reduced to 3.0% as compared to a rate of 3.3% pre-implementation. Moreover, the OASI Care Bundle was associated with a 20% *reduction in OASI risk* when individual characteristics, such as age, ethnicity, body mass index, parity, birthweight and mode of birth were taken into account (p=0.03), without affecting rates of caesarean birth or episiotomy. The OASI Care Bundle also requires a careful check of the perineum following birth, ensuring accurate diagnoses, which may have increased the OASI detection rate after the implementation of the care bundle. Therefore, the reduction of OASI rates that was found after implementation of the OASI	

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				Care Bundle is likely to be an underestimate of its true effect.	
Royal College of Midwives	Guideline	General	General	The RCM welcomes an update to the Intrapartum care for healthy women and babies NICE Guideline however, regrettably, the language and recommendations lack the usual high standards we expect from NICE. The implications of those recommendations on clinical and psychological outcomes for women, birthing people and families, along with the impact on service provision, safety and midwifery workforce has not been fully considered. We strongly recommend revising the draft guideline to account for the comments, edits, and suggestions we have detailed below. The RCM response was informed by consultation with our members via the RCM Consultant Midwives Forum and the RCM Professorial Group and in the OASI collaborative project with RCOG.	Thank you for your comment. We have addressed and responded to your individual comments.
Royal College of Midwives	Guideline	General	General	It is disappointing to note there is a general use of paternalistic language that permeates throughout this draft guideline. Women, having complete agency and autonomy over their bodies, birthing choices and	Thank you for your comment. Based on feedback from stakeholders a large number of changes have been made to the wording in this guideline to ensure it is more woman-centred.

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				preferences, should be enabled and free to make their own decisions with support and advice from healthcare professionals. Furthermore, the language used should support this stance. There are several examples of paternalistic rather than women centred language in this guideline, for example 'women should not…'.	
Royal College of Midwives	Guideline	005	007	This point could cause some confusion in practical terms, as it implies that only nulliparous women should be given the information about what to do in an emergency. We suggest that this is reworded to make clear that all women should be given information about what to do in an emergency, regardless of any previous pregnancies. Excluding a cohort of women from receiving safety information is putting them at a disadvantage, when their previous birth experience may have been at another health provider or in another country. Therefore all women should be given the information about how to contact their midwifery team and what to do in an emergency relevant to their chosen healthcare setting, for each pregnancy.	Thank you for your comment. The committee agreed that this antenatal information about labour should be given to all women and so removed the word 'nulliparous' as you suggest.
Royal College of Midwives	Guideline	006	014	Transfer times and audit. Transfer times should be calculated jointly	Thank you for your comment. The committee agreed that ambulance trusts would need to be

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				between the local commissioned ambulance trust and the senior midwifery leadership team. This will enable a realistic time scale to be established, against which a delay in transfer can be gauged and then effectively audited. This audit information can then be provided to women in counselling conversations around average transfer times.	involved in auditing local transfer times but that it was not necessary to provide this level of operational detail in the recommendation.
Royal College of Midwives	Guideline	006	016	This section should include a recommendation that consideration should be given to allocating additional time when discussions highlight a need to explore women's choices further, thereby allowing for completeness of counselling.	Thank you for your comment. There are multiple places in the guideline where discussions are recommended to explore women's choices and so we have not highlighted the need for additional time in this recommendation specifically.
Royal College of Midwives	Guideline	006	017	Commissioners and providers. When discussing protocols for the transfer of women between places of care, partners within the ambulance trust need to be considered. Consider rewording this for their inclusion; Commissioners and providers including representatives from the local commissioned ambulance trust should ensure that...	Thank you for your comment. The committee agreed that ambulance trusts would need to be involved in protocols relating to transfer of care but that it was not necessary to provide this level of operational detail in the recommendation.
Royal College of Midwives	Guideline	007	003	In respect of ensuring multidisciplinary clinical governance structures are in place, these structures should also include representatives from the local commissioned ambulance trust who should be an active	Thank you for your comment. The committee agreed that that the recommendation suggested the minimum involvement in clinical governance structures, but that depending on the topic under consideration this may require

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				member of review meetings where ambulance transfers have been required.	additional members, such as the ambulance trust, but it was not necessary to list all possible participants in the recommendation.
Royal College of Midwives	Guideline	008	006	The types of serious medical problems that can affect babies & appendix A – adverse outcomes for different places of birth. Appendix A does not break down the information regarding medical problems that can affect babies by birthplace. This information would aid discussions with women and birthing people and those that support them. Appendix A should be amended to include information to reflect all birth places against the outcome measures. Furthermore, for context, Appendix A should also include the risks of a multiparous woman receiving universal care (low risk) birthing in an obstetric setting. There is little narrative throughout this guideline about the risks of adverse outcomes owing to interventions due to birthing in an obstetric setting.	Thank you for your comment. The evidence for planning place of birth, except for consideration of the role of BMI, was not considered as part of this update. However, updating place of birth has already been prioritised by NICE as needing an update and your comment about Appendix A will be considered as part of this update. Please see: https://www.nice.org.uk/guidance/cg190/resources/2023-exceptional-surveillance-of-intrapartum-care-for-healthy-women-and-babies-nice-guideline-cg190-11443418173/chapter/Surveillance-decision?tab=evidence#planning-place-of-birth
Royal College of Midwives	Guideline	008	008	'Give women' is not empowering or woman centred language. Amend this to; Discuss with women the following information.	Thank you for your comment. This has been changed to 'Discuss with women….' as you suggest.
Royal College of Midwives	Guideline	008	018	Availability of birthing pools/access to medicines and analgesia.	Thank you for your comment. These recommendations have not been amended as

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				These figures could be presented in numerical values (xxx women in 1000 receives analgesia of her choice when requested) to improve the clarity of this information.	the availability of birthing pools and pain relief was not included as part of this update. However, your suggestion will be passed to the NICE surveillance team for consideration as part of a future update.
Royal College of Midwives	Guideline	008	023	The updated guidance states 'the delay in care this may cause'. This is unclear and needs more discussion about what a delay in care may materially make – for example if the woman is transferred for a postpartum haemorrhage, emergency care may continue during transfer. Evidence does not show the transfer to have adverse outcomes on the mother and baby and whilst the transfer is occurring, the team in the obstetric unit are making preparations to receive, at the ambulance if required. Whilst the importance of transfer process discussions is understood, a blanket statement such as this weighs against homebirth or stand alone MLU when presented like this without nuances and caveats. Please also include a section that details that the ambulance service have the expertise in maintaining communication throughout, and will advise who should or should not travel with her and how her baby is to be transported.	Thank you for your comment. The recommendation has been amended to state that transfer will lead to a delay in obstetric or neonatal care. Further details about transfer, including communication and who can travel are already included in the separate section about 'Transfer of care and changing place of birth' and so have not been repeated here.

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Royal College of Midwives	Guideline	008	025	Please include an additional point about when birth planning with BMI 40 or greater, consideration should be given to including the local provider of ambulance services to ensure the availability of bariatric ambulances.	Thank you for your comment. The committee discussed this but agreed that the availability of bariatric ambulances was a local operational issue and outside the scope of the intrapartum care guideline.
Royal College of Midwives	Guideline	010	Table 2	Table 2 conflates several adverse neonatal outcomes making it a challenge to understand the risk/benefit balance. This table contains data for stillbirth, neonatal death, and the baby requiring neonatal care with no further detail to the level of neonatal care that was required or the longer term outcomes. Additionally, this table is not clear about how these figures are calculated, for example are neonatal admission and neonatal death counted as two numbers even if for the same baby? Furthermore are all the admissions and neonatal deaths unexpected? We suggest dividing table 2 into multiple tables; one for stillbirth, one for neonatal death and one for neonatal unit admission, including the reason for admission. Whilst all maternity service workers understand the importance of preserving the mother and baby dyad, a distinction should be made between an admission for TTN and an	Thank you for your comment. We have reported the outcomes stillbirth, neonatal death, and baby needing neonatal care together as the study that provided data on these outcomes reported them as a combined composite measure. We do not have the individual counts for the outcomes separately so are unable to provide further information regarding the individual components of the composite endpoint. We also do not have the information to inform the reasons for admissions or deaths, and are unable to provide detail on whether they were unexpected. The committee have discussed this composite measure, and agree that individual outcomes would provide more detail, nonetheless they agree that the composite outcome as reported in the table is still useful as it does provide information that can be considered when planning place of birth.

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				admission for HIE due to the longer term outcomes for baby.	
Royal College of Midwives	Guideline	011	Table 4	This table is unclear – average rate of stillbirth, neonatal death or baby needing additional neonatal care. Is this data referring to all multiparous women, or just those who choose a homebirth? The table should be separated, presenting the data as all multiparous women and multiparous women who choose a homebirth to prevent conflation of risks.	Thank you for your comment. In response to stakeholder feedback we have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The recommendation, the rationale and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them.

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Royal College of Midwives	Guideline	011 & 012	Tables 004 & 005	It is concerning that there are large sections of both tables 4 and 5 which have no data. The unavailability of data within these tables will make it difficult, if not impossible, for women to accurately compare risks and benefits of the options that are available to them.	Thank you for your comment. In response to stakeholder feedback we have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The recommendation, the rationale and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them.
Royal College of Midwives	Guideline	018	Table 11	Other factors indicating increased risk and suggesting planned birth at an obstetric unit; Small for gestational age here is referred to as less than 5th centile and uses SBLCBv2 as the source. Referring to SBLCBv2 it refers to 3rd centile or less for the babies at most risk, rather than 5th centile. Please amend this to 3rd centile.	Thank you for your comment. This has been changed to less than the third centile so it is in-line with Saving Babies Lives version 2 (and 3) and the NICE guideline on fetal monitoring in labour.

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Royal College of Midwives	Guideline	019	005	Senior or Consultant midwife. Generally, a senior midwife is considered those to be agenda for change (AFC) Band 7 and above although there is no nationally agreed definition. Discussion and counselling of women in regards place of birth, for those with additional factors requiring further discussion, should be undertaken by a consultant midwife (or obstetrician if there are obstetric issues). A consultant midwife must oversee any clinics run by 'senior midwives' and support these more junior staff and the consultant obstetric team. Each organisation must have a minimum of 1 whole time equivalent (WTE) consultant midwife per 1:900 low risk birth and an additional 1 WTE consultant midwife per midwife led unit (MLU). If the organisation cannot provide a consultant midwife, the senior midwife must have undergone development and education to be conversant in evidence/research, audit and advanced care planning and multidisciplinary team (MDT) communication and governance. Please amend this statement to read consultant midwife, or other appropriately trained senior midwife under the supervision of a consultant midwife.	Thank you for your comment. The recommendation has been amended to state that that the further discussions must be with an appropriately trained or consultant midwife. The committee agreed it was not necessary to state that the senior midwife worked under the supervision of a consultant midwife.

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Royal College of Midwives	Guideline	020	017 & 018	States 'provide a model of care that supports 1:1 care in labour for all'. Evidence (Cochrane 2016) shows improved experiences and outcomes for women in a caseloading or continuity of carer model. Women should be informed of this when making decisions about their care pathway. This is as important as where they choose to give birth. Not all areas have MLU's, however this is in the NICE document. Continuity, as a model, should be included as a care choice in NICE, due to the evidence that supports it as good as, or better, than traditional models of care. This is shown to be of greater impact for those identified in lower socio-economic areas. Women from lower socio-economic groups, and those experiencing severe and multiple disadvantage were disproportionately represented in recent MBRRACE reports. We suggest amending to include an additional bullet point stating that maternity services should aim to offer caseloading or continuity of carer as a model of care in line with local staffing ratios and national guidance. Additionally we suggest including a table to compare outcomes when women are cared for in a standard way, compared with those who are cared for in a caseloading	Thank you for your comment. Midwifery Continuity of Care has been rolled out across England and should be the default model of care since March 2023, although we recognise that there are some areas where safe staffing levels may not allow for this to be fully implemented. As this is the default model of care recognised by NHS England we have not added this to the guideline.

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				or continuity of carer model of care – similar to the tables used to illustrate to outcomes for BMI or choice of place of birth.	
Royal College of Midwives	Guideline	022	002	To establish communication with the woman. Add an initial, additional bullet point to ask the woman what she prefers to be called.	Thank you for your comment. This additional bullet point has been added as you suggest.
Royal College of Midwives	Guideline	022	012	We suggest rewording this bullet point to read; Offer information about the pain relief options that are available to her and give the opportunity to discuss this in more detail if she wishes, reiterating that this conversation can be revisited as often as is required.	Thank you for your comment. The committee agreed that in many cases women had already made choices about pain relief options before labour which would have been recorded in their birth plan, and did not want to have to repeat the whole discussion when they met their midwife at the beginning of labour. The recommendation was therefore written to establish if the woman had already made decisions or if she needed information to make a decision. It has not therefore been reworded as you suggest.
Royal College of Midwives	Guideline	024	014	When arranging transfer from 1 location to another. Please include an additional bullet point to read; The midwife provides a structured hand over to the ambulance crew to enable a shared mental model should any or ongoing resuscitation measures be required. During transfer, where there is a change in the condition of the woman, or if the birth takes	Thank you for your comment. The recommendations already include the need to carry out a handover of care, but ambulance services will already have protocols in place to deal with intrapartum transfers and for the use of seatbelts so the committee did not agree to add more detail into the recommendations about this.

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				place, discussion should take place about the roles and responsibilities to ensure the safety of the woman and baby and the environment. During ambulance transfers it will be necessary for the woman and the midwife to be secured in the ambulance saloon by way of seatbelts or a harness.	
Royal College of Midwives	Guideline	025	006	Monitoring of the woman throughout transfer, including auscultation of the fetal heart where possible and safe to do so, whilst important, must not compromise the safety of women, midwives or ambulance crew. Further consensus is required around optimum transfer processes that recognise the ongoing care needs of a pregnant woman, who may be in labour, or where a maternal or newborn emergency arise. Transfer processes should be agreed between local commissioned maternity service providers and the local ambulance service NHS trust.	Thank you for your comment. The committee agreed that ambulance services will already have protocols in place to deal with intrapartum transfers and so agreed details of this did not need to be included in the recommendations.
Royal College of Midwives	Guideline	026	007	The choice of language in this bullet point is not empowering to women and no similar comparisons have been used in other parts of the guidance. For example, women using pharmacological analgesia often need further analgesia, going on to have regional analgesia, but this is not described in the	Thank you for your comment. The wording of this bullet has been changed to advise that other forms of pain relief can be used with TENS, as you suggest.

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				guidance. This implies that TENS is a poor or lesser method of analgesia. We would strongly suggest rewriting this to read that other forms of analgesia can be used alongside TENS if required by the woman.	
Royal College of Midwives	Guideline	026	028	Please use the anatomical term Rhombus of Michaelis.	Thank you for your comment. This has been changed to the Rhombus of Michaelis as you suggest.
Royal College of Midwives	Guideline	031	018	The implications of this recommendation on service provision have not been fully considered. This statement may lead women to expect regional analgesia in the latent phase of labour. In practical terms, this may not be feasible owing to staffing levels, due to the level of monitoring that would be required and the requirement for one to one care at a time when the clinical picture does not mandate this.	Thank you for your comment. The committee discussed this and agreed that it was not necessary to specifically state the epidurals should be used in the latent first stage of labour, but that they should be used in any woman with any level of pain who requested one. This statement relating to use in the first stage of labour has therefore been removed. As this recommendation has been in the guideline since 2007 the committee did not think this would increase the number of women requesting epidurals in the latent phase of labour.
Royal College of Midwives	Guideline	032	024	Cardiotocograph (CTG) before epidural. Please include a recommendation for how long prior to epidural insertion the CTG should be performed.	Thank you for your comment. The committee amended this recommendation to clarify that cardiotocography should be carried out for at least 30 minutes during establishment of regional analgesia and after administration of each bolus of 10 ml or more, which was in line

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					with a previous recommendation that has been in the guideline since 2007.
Royal College of Midwives	Guideline	032	024 - 026	The updated guidance draft states to maintain continuous cardiotocography while the woman has an epidural in situ. The recommendation to maintain continuous cardiotocography is based on the 'knowledge and expertise' of the committee (evidence review page 137 1.6.34). The evidence around maintaining the continuous cardiotocography for the duration of the epidural does not support this recommendation, if the woman is stable with normal observations. We suggest removing this recommendation due to a lack of evidence to support this.	Thank you for your comment. The committee amended this recommendation to clarify that cardiotocography should be carried out for at least 30 minutes during establishment of regional analgesia and after administration of each bolus of 10 ml or more, which was in line with a previous recommendation that has been in the guideline since 2007.
Royal College of Midwives	Guideline	034	003	Prelabour rupture of membranes at term. We suggest the addition of 'midwife' prior to maternity unit in the list of who the woman is to contact for an initial triage assessment. If women are part of a caseloading model of care or in a continuity of carer model, their initial point of contact is the own midwife, or team of midwives, rather than their maternity unit. This is seen throughout this draft guidance (page 34 line 30, page 37 line 14). We suggest reordering the language and listing	Thank you for your comment. Midwife has been added as the first point of contact in all the places you suggest

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				midwife before maternity unit as the midwife is the primary point of contact.	
Royal College of Midwives	Guideline	037	017	In order to support ensuring that the woman has choice to accept or decline care, we suggest amending the paternalistic language seen throughout the draft guidance. We suggest rewording this to; Offer to carry out a face to face assessment of labour.	Thank you for your comment. This recommendation relates to the place where the assessment can be carried out, so in this context the committee agreed to leave the wording as 'carry out…'.
Royal College of Midwives	Guideline	038	005	The triage midwife should document the guidance provided within the electronic record for the woman and where necessary document whether this is the first or a subsequent call made. Where a maternity service has both electronic and paper based records, this information should be accessible to all members of the maternity team.	Thank you for your comment. Different maternity units will have different forms of written or electronic records so the committee agreed it was not appropriate to include the finer details of where this information should be documented.
Royal College of Midwives	Guideline	038	007	MBBRACE recommended national guidance on fetal and maternal wellbeing monitoring for those in hospital during the latent phase. This should include the frequency, nature and interpretation of the fetal heart. This update is an opportunity to provide guidance to staff on how often maternal observations and fetal heart auscultation should be carried out in the latent phase for those women who choose to remain in the hospital or MLU, and eliminate the local variation.	Thank you for your comment. The committee did not consider any evidence on fetal monitoring needed during the latent stage of labour so have not amended these recommendations, but will pass this suggestion to the NICE surveillance team for consideration as part of a future update.

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Royal College of Midwives	Guideline	039	003	In the initial assessment of a woman or birthing person in the first stage of labour, record pulse, blood pressure and temperature. It is generally accepted that respiratory rate is part of the holistic assessment and is an early, extremely good indicator of wellbeing (Rolfe, 2019) with some reports that respiratory rate is superior to most other vital signs in it's sensitivity to identifying pathological conditions (Nicolò, 2020). We suggest the inclusion of respiratory rate as a recommendation for routine assessment in light of the above.	Thank you for your comment. Respiratory rate has been added to the list of observations.
Royal College of Midwives	Guideline	040	014	Observations of the woman. Please include; record the respiratory rate of the woman and ensure it lies within normal parameters.	Thank you for your comment. Respiratory rate has been added to the list of observations, and normal parameters included.
Royal College of Midwives	Guideline	041	015	Suspected or diagnosed large for gestational age. To recommend transfer to an obstetric unit from an MLU or homebirth setting will considerably reduce the number of women who are able to utilise these places of birth. Evidence is needed in order to justify this recommendation. This recommendation, in part, contradicts the recommendations in NICE guidance 207	Thank you for your comment. Large for gestational age has been removed from this recommendation.

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				where it is recognised that large for gestational age is not an independent risk factor.	
Royal College of Midwives	Guideline	041	026	In order for this guideline to be woman centred, consideration should be given to ensuring that the language used empowered women and birthing people. https://www.rcm.org.uk/media/6234/re_birth_summary_.pdf In light of the above, please ensure women are mentioned at any point where discussion is recommended. Consider rewording to; discuss this with the woman and the coordinating midwife.	Thank you for your comment. The need to discuss this decision with the woman has been added into this recommendation, as you suggest.
Royal College of Midwives	Guideline	042	020	Recording observations during the first stage of labour. It is generally accepted that respiratory rate is part of the holistic assessment and is an early, extremely good indicator of wellbeing (Rolfe, 2019) with some reports that respiratory rate is superior to most other vital signs in its sensitivity to identifying pathological conditions (Nicolò, 2020). We suggest an amendment to include the woman's respiration rate in the usual assessment throughout labour.	Thank you for your comment. Respiratory rate has been added to the list of observations.

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Royal College of Midwives	Guideline	043	003	We suggest this is reworded; Discuss and if the woman consents, carry out an hourly risk assessment…	Thank you for your comment. As almost every action in the guideline requires discussion and consent, an over-arching recommendation has been added to the section of the guideline on care throughout labour to state this, rather than repeating it for every individual recommendation.
Royal College of Midwives	Guideline	047	022	This recommendation does not make sense – after amniotomy the membranes would not be intact.	Thank you for your comment. The phrase about membranes being ruptured or intact has been removed to make this recommendation clearer.
Royal College of Midwives	Guideline	051	018	We welcome the recommendation for all women either with or without an epidural in place they are to be encouraged and supported to give birth in any position she finds comfortable.	Thank you for your comment.
Royal College of Midwives	Guideline	052	005	The RCM welcomes the recommendation for spontaneous, open glottis pushing technique for women without an epidural.	Thank you for your comment.
Royal College of Midwives	Guideline	052	011	We suggest a reword to; offer to carry out further assessment after 1 hour.	Thank you for your comment. This change to 'offer assessment' instead of 'assess' has been made.
Royal College of Midwives	Guideline	052	016	We endorse the recommendation that nulliparous women with an epidural be offered delayed pushing for 2 hours in the second stage.	Thank you for your comment.

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Royal College of Midwives	Guideline	053	007	The RCM welcomes the inclusion of the recommendation to offer a warm compress to the perineum.	Thank you for your comment.
Royal College of Midwives	Guideline	053	011	The evidence around perineal massage as a technique to reduce perineal trauma refers more to antenatal massage, rather than perineal massage in labour. We suggest amending this recommendation to advise women that antenatal perineal massage from 34 weeks gestation has been shown to reduce the likelihood of perineal trauma, better wound healing, and a reduction in the reports of ongoing perineal pain.	Thank you for your comment. The evidence was reviewed only for use of intrapartum massage, not in the antenatal period, so no recommendations for antenatal use have been made.
Royal College of Midwives	Guideline	053	016	This updated guidance refers only to episiotomy as an adverse outcome. Whilst the impact of an episiotomy can not be underestimated on women in the short and longer term, it should be recognised that episiotomy can be a useful intervention to prevent more serious perineal trauma, which is referenced elsewhere in this guidance.	Thank you for your comment. When designing the protocol for this review the committee agreed that, when looking at less invasive perineal interventions, it would be useful to know if they reduced the risk of more invasive perineal interventions such as episiotomy. So, in this context, although episiotomy is an intervention, the committee included it as an outcome. However, you are correct that in some cases carrying out an episiotomy could be beneficial if it prevented a serious tear, but the reporting of the evidence did not allow this level of detail to be determined. However, the committee reviewed the evidence for hand

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					position again, and as it was low quality they agreed it was insufficient to provide guidance on the best hand position and so have removed this recommendation and instead just made a research recommendation.
Royal College of Midwives	Guideline	057	012	We suggest rewording this to ensure women's consent to procedures and recommendations is actively sought. Please reword to; If there is a delay in the second stage of labour and the recommendation is to transfer the women to obstetric-led care, if after discussion the woman consents, follow the general principles for transfer of care.	Thank you for your comment. There are numerous places throughout the guideline where decisions are made about care and a women would be involved in these decisions and consent sought. An overarching recommendation has therefore been added to the section of the guideline about care in all settings to state this, instead of repeating it in each individual recommendation.
Royal College of Midwives	Guideline	057	026	We suggest rewording this to ensure that women's consent to procedures and recommendations is actively sought. Please reword this to; If the decision is made to start oxytocin and, after discussion the woman consents, ensure that the time…	Thank you for your comment. There are numerous places throughout the guideline where decisions are made about care and a women would be involved in these decisions and consent sought. An overarching recommendation has therefore been added to the section of the guideline about care in all settings to state this, instead of repeating it in each individual recommendation.
Royal College of Midwives	Guideline	075	019	Please include respiratory rate in the usual undertaking of maternal observations. General good practice would be for these observations to be recorded on a MEWS chart and escalated appropriately.	Thank you for your comment. Respiratory rate has been added to the list of observations. The committee were aware that MEOWS charts were being rolled out and that when this was the case then the MEOWS chart could be used

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					to observe trends, but as a national chart has not yet been agreed they did not add this to their recommendation..
Royal College of Midwives	Guideline	086	022	Sterile water injections and how the recommendations might affect practice. We welcome the inclusion of the sterile water injections as analgesia and agree that this is an inexpensive intervention. There will however be some resource impact for the NHS as, where this practice does is not already in use, there will be a requirement for training, theoretical and practical, with supervision and support for those who will be administering this. There will also be ongoing updates required. We suggest amending this to reflect that there will be some initial resource impacts for the NHS in maternity services where this practice is not already commonplace, with minimal resource requirements once this is established practice.	Thank you for your comment. It is not standard NICE practice to include the training to implement a new recommendation in the assessment of the impact of the change. Once the recommendation becomes standard practice the costs will be, as you suggest, minimal. The statement has not therefore been changed.
Royal College of Midwives	Guideline	098	018 Table A	We welcome and support this decision since the guideline is for women receiving universal care, the previous version was unbalanced by many pages on EFM that was not relevant for the population this guideline is designed for.	Thank you for your comment.

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Royal College of Midwives	Guideline	098	021 Table B	The term 'shared decision making' is highly contentious. The decision is not shared – it is the woman's. 'Shared discussions' is fine. Shared decision making should not be used. There may be other terminologies, but the woman must have the final say. Agree that options should be considered in pregnancy, subject to the fact that women change their minds while in labour (and during labour). Decisions should be constantly reappraised and discussed from pregnancy onwards where the woman want to have these discussions https://evidence.nihr.ac.uk/alert/midwives-need-support-to-involve-women-in-decision-making-during-labour/	Thank you for your comment. The use of the term shared-decision-making in the guideline has been amended to supported decision-making to reflect that it is the woman's decision. The recommendations already state that women can change their mind at any point during pregnancy or labour, but do not recommend that decisions should be constantly appraised, as women do not like being asked to repeatedly make or reconfirm the same decisions over and over again.
Royal College of Midwives	Guideline	098	021 Table B	**Evidence:** Decision aids, as a standard part of practice, have the potential to ensure women are informed of their options and encourage shared discussions about place of birth. There is evidence that using a decision aid as part of a shared decision discussion increases women's confidence. Wiggins et al (2023) https://doi.org/10.1016/j.midw.2022.103564	Thank you for your comment. We agree that decision aids are important and these will be considered by NICE when implementation support is being planned.

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Royal College of Midwives	Guideline	099	Table B 1.3.2	**Evidence:** The MyBirthPlace decision aid, used as part of a shared decision discussion, has been found to be an acceptable and useful resource. It also increases women's confidence regarding place of birth. Wiggins et al (2023) https://doi.org/10.1016/j.midw.2022.103564	Thank you for your comment.
Royal College of Midwives	Guideline	100	Table B 1.6.30	It is not clear what 'mobilise' means? Does it mean just moving legs while in bed/re-positioning or walking around? If the latter the risks should be fully assessed against benefits to ensure evidence-based recommendations are made. It is important that women are not led to believe that if they have an epidural they will still be able to mobilise fully. **Evidence:** The COMET study, that found that, while 'mobile epidurals' did result in more lower limb power in women when compared to high dose epidural controls, this did not reach 100% power (as for women who did not have an epidural) and only resulted in less than 40% of women in both of the 'mobile epidural' arms actually standing or walking for 1hr or more in first stage, and the capacity to do this diminished as labour progressed - very few did so in second stage. Overall there was no difference in the primary	Thank you for your comment. Mobilise in this recommendation means to stand or walk (as opposed to 'changing position'). The recommendation makes it clear that women should be assessed by their midwife before mobilising to ensure their safety. The earlier recommendation on discussing the risks and benefits of epidurals warns women that their mobility will be reduced.

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				outcome ('delivery mode') - instrumental birth was slightly lower with one of the techniques used (combined spinal epidural). *Wilson MJ, MacArthur C, Cooper GM, Shennan A; COMET Study Group UK. Ambulation in labour and delivery mode: a randomised controlled trial of high-dose vs mobile epidural analgesia. Anaesthesia. 2009 Mar;64(3):266-72* *https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2008.05756.x* A more recent review again indicates that there is very little strong evidence that mobile epidurals make a big difference (i.e. that they bring a labour with an epidural to a similar point physiologically to one without). This does seem to be important for women to know...: *de Verastegui-Martín M, de Paz-Fresneda A, Jiménez-Barbero JA, Jiménez-Ruiz I, Ballesteros Meseguer C. Influence of Laboring People's Mobility and Positional Changes on Birth Outcomes in Low-Dose Epidural Analgesia Labor: A Systematic Review with Meta-Analysis. J Midwifery Womens Health. 2023 Jan;68(1):84-98*	

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				https://onlinelibrary.wiley.com/doi/10.1111/jmwh.13446	
Royal College of Midwives	Guideline	100	Table B 1.18.10	**Evidence:** Agree – BUT – vaginal examination should also be accompanied by an assessment of the woman's overall behaviour, feelings and responses and assessment of the wellbeing of the fetus, and by assessment of contraction strength and frequency. As the current Cochrane review in this area notes, a VE by itself is not a good predictor of labour progress. *Downe S, Gyte GML, Dahlen HG, Singata M. Routine vaginal examinations for assessing progress of labour to improve outcomes for women and babies at term. Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD010088. DOI: 10.1002/14651858.CD010088.pub2.* https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010088.pub2/full	Thank you for your comment. The recommendations on vaginal examination form part of a large section on the assessment of the women and baby so it is not suggested that this particular examination predicts progress of labour.
Royal College of Midwives	Guideline	100	Table B 1.8.29	There is potential to retain a differential response to meconium depending on the grade. Whilst acceptable in principle, the language used here risks the transfer of a large number of women who have physiologically postmature pregnancies but	Thank you for your comment. The committee agreed that all meconium, before or after full-term, should trigger a discussion about the best place and type of care but this would very depending on the character of the meconium, the woman's preferences and other risk

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				who are healthy and with healthy babies. We propose amending to: Be aware that meconium is more common after full term, but should still trigger a full risk assessment and discussion with the woman about the option of transfer to obstetric-led care IF the meconium is thick and fresh, or if there are any additional concerns about the wellbeing of the fetus. [2023]	factors, so the recommendation will not necessarily lead to more women being transferred.
Royal College of Midwives	Guideline	100	Table B 1.8.23	Agree in principle. However there should be caution that this is not extended to large numbers of women who simply don't need to urinate and women are able to drink freely. If the latter is not the case, the issue may be dehydration and not an inability to urinate, the solution to which is to increase access to oral fluids, not to administer IV fluids and catheterise.	Thank you for your comment. There is already a separate recommendation about women drinking freely (1.8.17) and this recommendation has now been amended to advise that catheterisation should only be offered if there are ongoing concerns about a woman's ability to urinate.
Royal College of Midwives	Guideline	101	Table B 1.11.2	This needs more clarity. We suggest replacing the first bullet point with the following: When assessing the colour element of the Apgar score attention should be given to potential differences in babies from diverse race and ethnicity backgrounds: assess for colour and central oxygenation by looking at locations such as around the lips, inside the mouth at the mucous membranes	Thank you for your comment. The rationale for the amendments to the method of assessing the Apgar score are discussed in the Equality Impact Assessment so this detail has not been repeated in the guideline itself.

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				and tongue (Fair et al, 2023) assess peripheral oxygenation by looking at the colour of the nail beds. *Fair F, Furness A, Higginbottom G, Oddie S, Soltani H. Review of neonatal assessment and practice in Black, Asian, and minority ethnic newborns Exploring the Apgar score, the detection of cyanosis, and jaundice. Race and Health Observatory, 2023*	
Royal College of Midwives	Guideline	108	Table C Table 7	Agree in general – but the evidence on outpatient induction is still not well established. If an induction is needed, a woman is no longer suitable to receive universal care by definition and would require additional care. The drift towards outpatient induction should be accompanied by very robust audit of clinical outcomes and women's views and experiences. The same goes for the BMI categories and place of birth-robust evidence to support these decisions are needed.	Thank you for your comment. Outpatient induction is suggested as an option in the NICE guideline on inducing labour so the recommendations in the intrapartum care guideline are consistent with those. However, we agree that robust audit of clinical outcomes and women's views when practice or services change is very important.
Royal College of Midwives	Guideline	110	Table C Table 9	Need robust evidence review to support these decisions regarding BMI categories and age as they are both risk factors associated with adverse outcomes	Thank you for your comment. The changes to the recommendation on BMI were based on a review of the evidence. However the change to age-related risk was based on a consensus by the committee.

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Royal College of Midwives	Guideline	110	Table C 1.1.11 /1.4.1	As above, shared decision making is problematic in this context. It must be emphasised that normally the woman's decision should be final, even if care providers do not 'share' in it. Exceptions would be where the woman is incapacitated.	Thank you for your comment. Shared decision-making throughout the guideline has been changed to supported decision-making (except for the title of the NICE guideline on shared decision-making as this has not changed).
Royal College of Midwives	Guideline	115	Table C 1.3.1	**Evidence:** There is significant debate about the definition of early labour (Hanley et al, 2016). The signs and symptoms that women report may differ from those that midwives expect (Hundley et al, 2020). Definitions using cervical dilation also differ. WHO currently defines early labour as: "*The latent first stage is a period of time characterized by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilatation up to 5 cm for first and subsequent labours*." (WHO, 2018) *Hanley et al (2016)* http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0857-4 *Hundley et al (2020)* https://doi.org/10.1016/j.bpobgyn.2020.02.006	Thank you for your comment. The committee agree that that as they had not reviewed the evidence they were not aware of any reason to amend the dilatation from 4cm.

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				WHO (2018) https://apps.who.int/iris/bitstream/10665/260178/1/9789241550215-eng.pdf?ua=1	
Royal College of Midwives	Guideline	116	Table C 1.3.2 & 1.3.3	As mentioned in the draft guideline as well, this should not be limited to nulliparous women. All women should receive this information.	Thank you for your comment. This has been amended so that all women will receive this information.
Royal College of Midwives	Guideline	116	Table C 1.8.3	Agree, but it should be recognised that because some women have a long way to travel, have complex childcare arrangements or difficult travel scenarios, being at home or another planned place of birth may not be a good option for her. The woman should be supported to stay where she feels safe.	Thank you for your comment. The recommendation states that the assessment can take place in any setting.
Royal College of Midwives	Guideline	118	Table C 1.3.10	**Evidence:** Based on the Cochrane reviews, there is no evidence that these techniques cause harm, and on the basis of qualitative evidence and of anecdotal report, they are very helpful for many women. Since much of the rest of this guideline is based on expert opinion, and not formal evidence, it seems to be odd that these commonly used pain relief options cannot be offered to women. Those who cannot afford to provide them for themselves will be disadvantaged by this recommendation, leading to inequity. This recommendation should be reconsidered, in	Thank you for your comment. Acupuncture, aromatherapy and yoga were not included in the scope of this update and as the evidence was not reviewed it was not possible to consider changing the advice for these interventions. However, your comment will be passed to the NICE surveillance team who monitor guidelines to ensure they are up to date.

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				the light of qualitative evidence as well as the relevant Cochrane review. *Smith CA, Collins CT, Crowther CA. Aromatherapy for pain management in labour. Cochrane Database of Systematic Reviews 2011, Issue 7. Art. No.: CD009215. DOI: 10.1002/14651858.CD009215.* https://www.cochrane.org/CD009215/PREG_aromatherapy-for-pain-management-in-labour *Labour pain control by aromatherapy: A meta-analysis of randomised controlled trials* https://www.sciencedirect.com/science/article/pii/S187151921830221X	
Royal College of Midwives	Guideline	118	Table C 1.4.2	Agree – but this should be worded as 'carry out an assessment as the basis for advising women about their choice of place of birth' (and not 'to determine…) An additional section should be added 'carry out an assessment of women booked with consultant care to determine if any risk factors they had have resolved, and if they therefore should be offered a transfer to midwife-led care, given the advantages of this model of care for healthy women and babies.	Thank you for your comment. The committee discussed this but agreed in this instance determine was correct as this is an assessment carried out by the professional. If transfer of care were to be recommended by the professional then the options would be discussed with the woman and a supported decision made, as described in the recommendations of transfer of care. However, the committee agreed that some women may also be able to move from planned obstetric care to midwife led care and so the

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					recommendation has been revised to state this.
Royal College of Midwives	Guideline	120	Table C 1.4.3	There should be an emphasis that transfer should only be made with consent and if she doesn't consent, her wishes should be respected. Additionally, some of these conditions will result in large numbers of transfers. What is the evidence that each of them is associated with a large increase in risk for woman and baby? The risks in absolute numbers should be clearly set out as a basis for women's decision making.	Thank you for your comment. This section of the guideline was not included in the scope of this update so apart from minor improvements to wording the criteria for transfer were based on an evidence review conducted in 2013/2014 and have not changed. It is therefore unlikely that these recommendations will change the number of transfers which have been taking place since 2014. As the evidence has not been reviewed it is not possible to add risks in absolute numbers.
Royal College of Midwives	Guideline	128	Table C 1.5.2 1.5.3	Is there new evidence to support the change in recommendations regarding meconium? If there is no new evidence, we strongly suggest removing this recommendation, widening the number of women who will require transfer. If this recommendation remains, then including the additional risks of hospital or obstetric led birth for healthy women and babies should be added.	Thank you for your comment. The change in the meconium recommendations were made to reflect the new focus of the guideline on shared decision-making, and the committee's view that presence of any meconium should trigger a review, but that the ultimate decision to transfer or not should be made by the woman. The discussion of the benefits and risks of transfer would include a discussion of the differences between midwife-led and obstetric care.
Royal College of Midwives	Guideline	129	Table C 1.6.1	This should be changed to include the psychological state of the woman. Suggested amendment; Base any decisions about transfer of care on clinical findings,	Thank you for your comment. Addressing psychological concerns is addressed in the subsequent recommendation to this one.

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				behaviour and emotional state of the woman and discuss the options with the woman and her birth companion(s).	
Royal College of Obstetricians and Gynaecologists	Evidence review G	007	002	Grouping semi-recumbent, lithotomy and lateral birthing positions together is disappointing when evidence shows that lateral is a good position to improve success of spontaneous vaginal birth (BUMPES trial, 2017) and reduces the risk of third- and fourth-degree tears (OASI), whereas lithotomy is discouraged for spontaneous vaginal birth (Elvander et al, 2015). Some countries now discourage the use of lithotomy (and forceps) due to their increased risk of trauma (Gyhagen et al, 2021). With improved understanding of biomechanics, midwives can encourage women into positions that open the pelvic outlet more effectively than lithotomy.	Thank you for your comment. The committee decided during the formulation of the review protocol that all positions of birth (for both upright and recumbent) should be considered in our evidence review. However, studies with different classifications of positions of birth have not been pooled in our analysis. The 2 included studies in the evidence review (BUMPES 2017 and Golara 2002) have been analysed separately (not pooled) as the positions of birth were defined/classified differently in these studies BUMPES 2017 included left or right lateral positions in recumbent group and Golara 2002 had spending as much time as possible in bed or in a chair during the passive phase in recumbent group . Furthermore, Golara 2002 did not consider position of birth in the active pushing phase of the second stage. We did not identify evidence for lithotomy in our evidence review.
Royal College of Obstetricians and	Evidence review I	006	019	Table 1: Summary of the protocol – Episiotomy is listed in the PICO table as a critical outcome in the review of perineal care interventions to reduce perineal trauma and tears, yet the introduction to the evidence	Thank you for your comment. The protocols for the evidence reviews are agreed in advance of the review and when designing the protocol for this review the committee agreed that, when looking at less invasive perineal

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Gynaecologists				review (page 6) already acknowledges the benefit of episiotomy in reducing the risk of tear formation. Episiotomy may be better categorised as an intervention or control rather than an outcome in the PICO table. While it is not recommended as routine, nonetheless it is used to prevent severe perineal trauma and aid birth where clinically indicated. Non-randomised studies that have shown it can prevent severe perineal trauma are not included in this evidence review. The categorisation of episiotomy as a critical outcome thereafter introduces bias into the evidence review of perineal care techniques because it fails to account for its benefits where indicated or for specific modes of vaginal birth (i.e. forceps). We would also question the categorisation of first- and second-degree tears as critical outcomes in a review of techniques to prevent perineal trauma. While they are important outcomes, third- and fourth-degree tears are associated with the highest morbidity and long-term consequences. Similarly, while urinary incontinence in the first year after birth is deemed an important outcome, faecal incontinence after birth is neither listed as important or critical despite	interventions, it would be useful to know if they reduced the risk of more invasive perineal interventions such as episiotomy. So, in this context, although episiotomy is an intervention, the committee included it as an outcome. However, you are correct that in some cases carrying out an episiotomy could be beneficial if it prevented a serious tear, but the reporting of the evidence did not allow this level of detail to be determined. The committee were interested in all types of tears (first degree to fourth degree) and so included them all in the protocol, although they took into account when reviewing the evidence that third and fourth degree tears would more be serious for the woman. Thank you for highlighting faecal incontinence as an outcome of importance. The outcome of faecal incontinence in the first year after birth has now been added into the review as an important outcome alongside urinary incontinence, although no differences were found between any of the comparisons for which this outcome was available so it did not lead to any changes in the recommendations.

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				this being a more serious consequence of perineal trauma in childbirth.	
Royal College of Obstetricians and Gynaecologists	Evidence review I	007	009 - 011	Included studies - The RCOG is concerned that only three randomised controlled trials (RCT) were reviewed to determine the effectiveness of 'hands on' support, otherwise known as manual perineal protection or MPP, in reducing perineal trauma. Of those three RCTs, the primary outcome for McCandlish (1998) was perineal pain whereas Mayerhofer (2002) and Califano (2022) assessed any type of perineal laceration, yet none was designed nor powered to determine the effect of MPP on third- and fourth-degree tears. Aside from these study design limitations, there is a lack of clarity as to the method of 'hands on' support provided in the three studies as well as inconsistent application, with 'hands on' being used at the time of delivery of the head and not necessarily the shoulders. For example, in the studies by McCandlish (1998) and Mayerhofer (2002), 'hands poised' meant that the hand was not applied to the perineum or infant's head until the head was born. In McCandlish (1998), however, manual assistance for the birth of the shoulders was not provided, whereas in the study by Mayerhofer (2002), no	Thank you for your comment. The evidence that the hands on / hands poised technique recommendation was based on has been revisited by the committee and in the light of the quality ratings of very low to low quality this recommendation has been removed.

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				distinction was made between 'hands on' and 'hands off' for the assistance of the birth of the shoulders. This is relevant because third- and fourth-degree tears can occur as the shoulders deliver. Despite the lack of high quality RCT evidence to draw upon, something that NICE has acknowledged in its review by grading the three studies as of low to very low quality, their findings are being utilised to produce an updated recommendation on the effect of MPP and therefore inform future clinical practice.	
Royal College of Obstetricians and Gynaecologists	Evidence review I	011	024	Perineal massage in the second stage. There is no women's feedback on what could be deemed an invasive technique. We suggest removal of this recommendation and its replacement with antenatal perineal massage.	Thank you for your comment. Women's experience of labour and birth was included in the protocol as an important outcome but has not been reported for perineal massage as there was no evidence available from the included studies for this outcome. The committee noted that perineal massage is simple procedure, however some women may find it invasive to have it done during labour whilst experiencing contractions. Based on the evidence and committee experience, they agreed to recommend perineal massage as an alternative to a warm compress if women prefer it. This is discussed in the committee's discussion of the evidence. We are aware that

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					perineal massage can also be carried out antenatally, but that was not within the scope of the intrapartum care guideline and so the evidence was not reviewed.
Royal College of Obstetricians and Gynaecologists	Evidence review I	012	011 - 015	The qualitative evaluation of the OASI1 project (2016-18) sought to understand women's experiences of labour and birth, including their experiences of 'hands on' support (see reference below). Nineteen women were interviewed, with their feedback providing valuable insight. The OASI2 study (2021-23) has sought to expand upon in its evaluation of women's experiences with a survey of ca. 1200 women for the same purpose. The OASI2 evaluation is currently underway with publication expected in late 2023. Bidwell P, et al. Women's experiences of the OASI Care Bundle; a package of care to reduce severe perineal trauma (2021)	Thank you for your comment and for informing us about this evaluation of the OASI project. Details of this study have been passed to the NICE surveillance team who monitor guidelines to ensure that they are up to date.
Royal College of Obstetricians and Gynaecologists	Evidence review I	013	017 - 026	None of the randomised controlled trials (RCTs) on intrapartum perineal massage was powered for third- and fourth-degree tears (OASI). Stamp (2001) showed a reduction in OASI but was underpowered; Albers (2005) showed no difference between arms, whereas Harlev (2013) compared use of	Thank you for your comment. The quality of each outcome in a NICE evidence review is assessed following GRADE processes taking into account risk of bias of the individual studies, the inconsistency, imprecision and indirectness. The evidence for perineal massage was graded low to very low, and the

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				different types of oil/wax rather than showing that second stage perineal massage reduced tearing.	committee took this into account when making their recommendations, and made only a weaker 'consider' recommendation for massage, as an alternative for woman who preferred it to a warm compress (for which there was better evidence).
Royal College of Obstetricians and Gynaecologists	Evidence review I	015	005 - 010	During its development in 2014, the RCOG and RCM did not include warm compresses as one of the components of the OASI Care Bundle as at the time there existed wide variation in practice, whereas the care bundle aimed to introduce a standardised set of practices that could be applied consistently. We fully acknowledge the evidence that warm compresses can reduce the risk of severe perineal trauma and encourage their use by midwives and obstetricians independently of or alongside the OASI Care Bundle. The OASI2 study (2021-23) has promoted additional perineal care techniques such as warm compresses and antenatal perineal massage in its antenatal discussion guide for women, conference talks and teaching materials for clinicians as part of a range of practices women can choose as part of their birth plan to reduce third- and fourth-degree tears. We would contend that interventions such as	Thank you for your comment and your support for the recommendation for warm compresses. The evidence that the hands on / hands poised technique recommendation was based on has been revisited by the committee and in the light of the quality ratings of very low to low quality this recommendation has been removed. The committee recognised that the other aspects of the OASI care bundle include guidance on episiotomy angles and rectal examination, and that these aspects were also covered in the intrapartum care guideline so they made minor editorial amendments to the recommendations on rectal examination.

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				'hands on' (manual perineal protection) should not be considered in isolation but always as part of a combination of interventions that can be implemented together because the causes of third- and fourth-degree tears are complex. The US Institute for Healthcare Improvement (IHI) defines a care bundle as a small set of evidence-based practices that, when performed collectively and reliably, will likely result in better outcomes than when implemented individually. The development and implementation of the OASI Care Bundle was supported by the two principal national professional bodies representing maternity professionals and encouraged multidisciplinary teams to work together. The intervention was multifaceted and informed by a detailed theory of change, with women involved in all stages of the project to ensure that the implementation of the care bundle supported women's choice of birth position and the importance of communication during labour. The project team evaluated the OASI Care Bundle for clinical effectiveness as well as barriers and enablers to uptake in 16 participating units in England, Scotland and	

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				Wales (OASI1 project). OASI1 had a stepped-wedge design and was powered to detect changes in rates of third- and fourth-degree tears (the primary outcome) following the implementation of the OASI Care Bundle. The clinical results, published in BJOG, compared almost 28,000 singleton vaginal births that took place before implementation of the care bundle with 27,000 singleton vaginal births that took place after. OASI rates (third- and fourth-degree tears) in the implementation period reduced to 3.0% as compared to a rate of 3.3% pre-implementation. Moreover, the OASI Care Bundle was associated with a 20% reduction in OASI risk when individual characteristics, such as age, ethnicity, body mass index, parity, birthweight and mode of birth were taken into account (p=0.03), without affecting rates of caesarean birth or episiotomy. The OASI Care Bundle also requires a careful check of the perineum following birth, ensuring accurate diagnoses, which may have increased the OASI detection rate after the implementation of the care bundle. Therefore, the reduction of OASI rates that was found after implementation of the OASI Care Bundle is likely to be an underestimate of its true effect.	

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Royal College of Obstetricians and Gynaecologists	Guideline	026	027	1.6.14 Analgesia: sterile water injections: state who would give the injection and include a diagram of injection site	Thank you for your comment. The recommendation has been clarified to state that suitably trained midwives can administer sterile water injections. A diagram of the injection site has not been included as the site of injection would be part of the training required.
Royal College of Obstetricians and Gynaecologists	Guideline	037	040	Temperature over 37.5 1 hour apart – it is worth mentioning if it is acceptable to administer paracetamol	Thank you for your comment. The committee agreed that paracetamol should not be administered, so did not add this to the recommendations.
Royal College of Obstetricians and Gynaecologists	Guideline	044	015	1.8.23 Frequency of passing urine – should include volume of urine passed?	Thank you for your comment. The volume of the urine would only need to be assessed in certain circumstances and these are listed directly below in the second bullet point.
Royal College of Obstetricians and Gynaecologists	Guideline	050	012	1.9 Baby is visible – this should read the baby is visible and the cervix is fully dilated	Thank you for your comment. The bullet point above refers to the fact that the cervix is fully dilated so it has not been repeated in this bullet point.
Royal College of Obstetricians	Guideline	051	018	Rec 1.9.5 and 1.9.6 - The woman's position and pushing in the second stage. Encouraging an upright position and for	Thank you for your comment.

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and Gynaecologists				women to choose a position they find comfortable is a welcome addition to the guideline.	
Royal College of Obstetricians and Gynaecologists	Guideline	052	005	Rec 1.9.7 - Pushing techniques. We welcome the recognition of encouraging spontaneous, open glottis pushing 0in women without an epidural.	Thank you for your comment.
Royal College of Obstetricians and Gynaecologists	Guideline	052	013	Rec 1.9.9 - Pushing techniques. We welcome the recognition of delayed pushing for nulliparous women with an epidural for up to two hours.	Thank you for your comment.
Royal College of Obstetricians and Gynaecologists	Guideline	053	007	Rec 1.9.13 - Warm compress. We welcome this addition to the updated guideline.	Thank you for your comment.
Royal College of Obstetricians and Gynaecologists	Guideline	053	011	Rec 1.9.14 - Massage in the second stage as an alternative to warm compress. These two techniques should not be offered as if they have the same balance of acceptability to women or evidence that both techniques reduce trauma equally. Antenatal perineal massage from 34 weeks to reduce perineal	Thank you for your comment. Massage is not offered as an equal alternative - it is considered in women who prefer it to the warm compress - so would only be used if acceptable to the woman, and this has been added to the recommendation. The evidence was reviewed only for use of intrapartum

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				trauma is the more appropriate recommendation, as it is a well-evidenced technique also led by the woman rather than the clinician. Beckmann and Stock (2013), Abdelhakim et al (2020).	massage, not in the antenatal period, so no recommendations for antenatal use have been made.
Royal College of Obstetricians and Gynaecologists	Guideline	053	014	Rec 1.9.15 – Intrapartum interventions to reduce perineal trauma. We are concerned that this updated recommendation is based on a limited review of low quality evidence on interventions to reduce perineal trauma and a miscategorisation of episiotomy as only an adverse outcome rather than an intervention that can help to prevent severe perineal trauma (see rationale in subsequent comments).	Thank you for your comment. The committee reviewed the evidence for hand position again, and as it was low quality they agreed it was insufficient to provide guidance on the best hand position and so have removed this recommendation and instead just made a research recommendation.
Royal College of Obstetricians and Gynaecologists	Methods	011	013 - 017	Types of studies and inclusion/exclusion criteria – Given the lack of high quality evidence available from randomised controlled trials (RCT) on the effect of 'hands on' support, otherwise known as manual perineal protection or MPP, the RCOG is unsure as to why NICE has not expanded its inclusion criteria to accommodate the next best available evidence from non-randomised studies (NRS). Several non-randomised studies, particularly from Scandinavia, have shown a significant	Thank you for your comment. The aim of the NICE evidence review on perineal care was to identify the benefits or harms of individual interventions (for example warm compresses or hands on care) and this is best achieved using randomised controlled trials. The studies you are referring to, including the outcomes from the OASI project, assess the results from using a bundle of interventions. While the 'bundle' seems to improve care it is not known which of the included interventions has the best effect, or if one intervention is actually

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				reduction in the risk of third- and fourth-degree tears when MPP is applied, including those reviewed in Bulchandani et al (2015) as well as the clinical outcomes from the OASI1 project led by the RCOG and RCM. These NRS have all tested intervention programmes that include not just MPP but also other practices to support a slow, guided birth and reduce severe perineal trauma. These practices include good communication between the accoucheur and the birthing woman, training in the use of episiotomy if clinically indicated, and systematic examination of the vagina and ano-rectum to detect any tears after birth, all with the woman's consent. Therefore, we believe that MPP should not be considered in isolation but as part of a series of coordinated interventions that take place during the final moments of childbirth.	causing harm but is being balanced out by the beneficial effects of other interventions.
Royal College of Pathologists	Guideline	034	014 - 015	Rec 1.7.1 – We are concerned that the current wording of this recommendation may imply that only a history of group B streptococcus infection is important, whereas a history of colonisation is equally important. We are also concerned that the phrase 'prophylactic antibiotics in this pregnancy' does not make clear that the only time that antibiotic prophylaxis against GBS would be	Thank you for your comment. The recommendation has been amended to include group B streptococcus in this or a previous pregnancy, as you suggest, and the word 'intrapartum' has been added.

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				indicated is in the intrapartum period (intrapartum antibiotic prophylaxis)	
Royal College of Physicians	Guideline	044	015 - 022	We welcome this acknowledgement of four-hourly bladder reviews for healthy intrapartum women and birthing people. When fluid balance monitoring is adopted perinatally in low-risk settings, it can reduce acute kidney injury1 and iatrogenic hyponatraemia2. Fluid balance monitoring is an effective, virtually costless and non-invasive observation, and is an essential element of midwifery care which ensures optimisation of normal physiology. This does not require catheterisation unless clinically indicated. *1. Jim B, Garovic VD. Acute kidney injury in pregnancy. Seminars in Nephrology. 2017;37(4):378–85. doi:10.1016/j.semnephrol.2017.05.010* *2. The Regulation and Quality Improvement Authority. Guideline for the Prevention, Diagnosis and Management of Hyponatraemia in Labour and the Immediate Postpartum Period. 2017.*	Thank you for your comment.
Royal College of Physicians	Guideline	048	021 - 024	We welcome this addition in view of the prevention of peripartum hyponatraemia. However, we would recommend additionally addressing oral fluid intake. Encouraging	Thank you for your comment. An existing recommendation about drinking when thirsty (1.8.17) has been clarified and a new recommendation on fluid balance and bladder

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				women and birthing people to drink to thirst, unless clinically indicated, can prevent polydipsia and iatrogenic hypervolemic hyponatraemia. Whilst the prevalence is difficult to quantify, peripartum hyponatraemia can have catastrophic impact on pregnant people and their babies. We welcome fluid balance reviews during all intrapartum care episodes to avoid iatrogenic hyponatraemia via excess intravenous and oral fluid administration.	care (1.8.23) has been added, so this information has not been repeated here, but the committee addressed in this recommendation the possibility of intravenous fluids being given unnecessarily.
Sands	Comments form	Q1		**Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives.** It would not be difficult or challenging to implement the recommendations Sands are suggesting. Sands would like to recommend that in this guide HCPs be given guidance on bereavement care for new parents by adding an acknowledgement of the possibility of an intrapartum stillbirth or early neonatal death on the labour ward, as well as including a link to the National Bereavement Care Pathway (NBCP) guidance document about care for parents after stillbirths and early neonatal	Thank you for your comment. The committee discussed your comments but agreed that one additional recommendation would not be able to satisfactorily address the emotional issue when a baby is stillborn or dies soon after birth. As this situation is not currently covered by NICE guidelines the committee agreed to pass it onto the surveillance team at NICE for consideration for a future guideline dedicated to this topic.

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				deaths where those precious few moments of time with their newborn baby are key to parents long-term wellbeing. These guidelines were developed by Sands along with other charities. This pathway is evidence-based and has been widely adopted by over 200 NHS Trusts throughout England, Scotland, Wales and Northern Ireland. The link to the National Bereavement Care Pathway guidelines for stillbirth are here: Stillbirth Bereavement Care Pathway | National Bereavement Care Pathway (NBCP) (nbcpathway.org.uk) In addition to the National Bereavement Care Pathway, Sands has also produced 9 evidence-based bereavement care standards which could be added to the Intrapartum NBCP Standards | National Bereavement Care Pathway (NBCP) (nbcpathway.org.uk)	
Sands	Guideline	059		We are concerned that this recommendation, on page 59, states that HCPs should give 'space' for the family to meet their new arrival. However, there is no acknowledgement of or guidance on what staff should do in the event that the baby is unexpectedly stillborn or dies on the labour ward due to intrapartum events	Thank you for your comment. The committee discussed your comments but agreed that one additional recommendation would not be able to satisfactorily address the emotional issue when a baby is stillborn or dies soon after birth. As this situation is not currently covered by NICE guidelines the committee agreed to pass

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				and parents find themselves unexpectedly bereaved. Sands recommends there be an acknowledgement at the end of the section on labour care that unexpected stillbirth is a possibility, and guide staff to resources to inform and education them on best practice for managing the needs of unexpectedly bereaved parents at the time of birth.	it onto the surveillance team at NICE for consideration for a future guideline dedicated to this topic.
Swansea University and Hywel Dda Health Board	Guideline			The points related to fetal monitoring should align to national guidance. There is room for ambiguity in this guideline.	Thank you for your comment. The fetal monitoring guidance has now been moved into the separate NICE guideline on fetal monitoring in labour (NG229). All the remaining points which mention fetal monitoring in the intrapartum care guideline align with NG229.
Swansea University and Hywel Dda Health Board	Guideline	005	005 - 008	Can you include giving all women information about enhancing the normal physiology of labour.	Thank you for your comment. Methods to enhance the normal physiology of labour were not included in the scope of this update so this change has not been made.
Swansea University and Hywel Dda Health Board	Guideline	006	008 - 011	Not all health boards currently offer a homebirth service. Therefore women might feel disadvantaged by this guideline.	Thank you for your comment. The guideline provides recommendations to advise on the best possible clinical care, and this should include the option of a home birth for women who wish to have this. There may be situations where operational aspects (such as a shortage of midwives) need to be taken into consideration when implementing these

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					recommendations in individual cases but the committee agreed it was not within the remit of the guideline to provide advice on operational issues.
Swansea University and Hywel Dda Health Board	Guideline	010	Table 2 +3 + 4	This information is very confusing and doesn't support women to make choices. What about the comparison between long term and short term outcomes. Rates of stillbirth are these all stillbirths or at home?	Thank you for your comment. The committee agreed that the tables are very complicated so we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail, but this removes the expectation that midwives will discuss this data with all women. The recommendation, the rationale and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them. Comparing long-term and short-term outcomes was not possible based on the evidence identified for this review. The planned place of birth has now been included in the summary tables but no evidence on rate of stillbirth at home was available as an individual outcome.

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Swansea University and Hywel Dda Health Board	Guideline	019	Table 13	What about fetal growth.	Thank you for your comment. Reduced fetal growth is already included as a factor in Table 11 (now Table 7), which suggests planned birth in an obstetric unit.
Swansea University and Hywel Dda Health Board	Guideline	020	021	This is vague- clearer guidance is needed on this aspect of care.	Thank you for your comment. The committee thought this recommendation was very clear as it states that women should not be left on their own and did not see how it could be made any clearer.
Swansea University and Hywel Dda Health Board	Guideline	025	007	Auscultation during transfer is not always standard practice.	Thank you for your comment. The advice to carry out intermittent auscultation was added to the guideline as the committee were aware of situations where women were not monitored during transfer and so deterioration in the baby's condition was not identified. Although management may not be possible during transfer it may inform the urgency of action required on arrival at the obstetric unit.
Swansea University and Hywel Dda Health Board	Guideline	026	003 - 007	This is an example of a condescending language used throughout this guideline.	Thank you for your comment. The wording of this recommendation has been changed to 'if a woman wants to use TENS to manage her comfort during labour, support her choice' as the committee agreed this is more woman-centred.
Swansea University and Hywel Dda Health Board	Guideline	031	003	Remove this statement as it contradicts line 4. This is not always the case.	Thank you for your comment. The committee agreed that a working epidural will provide more effective pain relief than opioids, but that occasionally this did not happen immediately

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					after insertion and adjustment or resiting may be necessary, and that women should be warned of this possibility.
Swansea University and Hywel Dda Health Board	Guideline	047	022	This line does not make sense.	Thank you for your comment. The phrase about membranes being ruptured or intact has been removed to make this recommendation clearer.
University Hospital Southampton NHS Foundation Trust	Guideline	010	Table 2 & 3	Tables with stillbirth data for nulliparous and multiparous women are a bit confusing. Firstly, it would be expected for the tables to display the same types of data for nulliparous and multiparous women. Secondly, appreciate Birthplace lumped together perinatal death and neonatal unit admission but imagine it's quite alarming to a lay person looking at the figures. Could you maybe change the order of the title so neonatal unit admission comes first rather than stillbirth? The tables don't say anything about place of birth and outcomes where raised BMI. Could you commission an infographic to go with this guideline as it won't be feasible for a community midwife to go through all these figures in a birth planning appointment and expensive/time consuming for each hospital to create an information leaflet.	Thank you for your comment. We have amended the summary tables in the guideline to include evidence for multiparous and nulliparous women planning birth in an alongside midwifery unit to demonstrate that the risks are increased for nulliparous women but not for multiparous women, as you suggest. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail, but this removes the expectation that midwives will discuss this data with all women. To keep the outcomes consistent with how they are described in the evidence report we have not reordered the wording in the title of the tables. The recommendation, the rationale

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					and the committee's discussion of the evidence now make it clear that the evidence provides details on outcomes for women with different BMIs, different parity and in different places of birth but cannot prove causation between these different factors. However, the committee agree that the recommendations can help women consider what might be the best place of birth for them. Because of the multidimensional nature of the data we do not think an infographic will be possible but we will pass your request to the NICE team responsible for implementation support.
University Hospital Southampton NHS Foundation Trust	Guideline	018	Table 11	Other factors indicating increased risk and suggesting planned birth at an obstetric unit Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound as defined in Saving Babies Lives version 2) The new NICE fetal monitoring in labour guideline states to offer CTG if <3rd centile or if <10th if abnormal doppler, reduced liquor, reduced growth velocity. This IPC guideline adding 5th centile as another parameter may lead to confusion.	Thank you for your comment. This has been changed to less than the third centile so it is in-line with Saving Babies Lives version 2 (and 3) and the NICE guideline on fetal monitoring in labour.
University Hospital Southampton	Guideline	024	011	Is there agreed national guidance on what constitutes category 1 and category 2 for maternity?	Thank you for your comment. The committee agreed that these categories for ambulance transfer (category 1, category 2 etc) are

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NHS Foundation Trust					nationally agreed and define the ambulance service anticipated response times. However, the choice of which category to request for each individual transfer would be decided locally depending on the clinical situation and urgency.
University Hospital Southampton NHS Foundation Trust	Guideline	025	006 - 008	The recommendation to monitor the woman throughout the transfer including IA will be challenging in practice due to the importance of maintaining safety of those staff performing the monitoring and inability to change the management mid-transfer (i.e. unable to convert from IA to CTG, potential for increased staff and woman's distress/ anxiety)	Thank you for your comment. The advice to carry out intermittent auscultation was added to the guideline as the committee were aware of situations where women were not monitored during transfer and so deterioration in the baby's condition was not identified. Although management may not be possible during transfer it may inform the urgency of action required on arrival at the obstetric unit.
University Hospital Southampton NHS Foundation Trust	Guideline	030	006	Locally we don't use CTG with remifentanil unless there are other risk factors.	Thank you for your comment. The recommendation has been amended to state that CTG is only needed if there are other risk factors.
University Hospital Southampton NHS Foundation Trust	Guideline	034	028	The recommendation for review in person within 6 hours of initial phone triage with term pre-labour rupture of membranes for women without risk factors will be challenging for maternity services in view of staffing and capacity. What is the evidence base for this time restriction and how will it change care	Thank you for your comment. The committee agreed that 6 hours may be too short a time period and have amended to 'within 12 hours'.

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				provided? (given options are immediate IOL in which case immediate review, or expectant up to 24 hours. Review within 12 hours may be more practical.	
University Hospital Southampton NHS Foundation Trust	Guideline	051	018	In situations where assisted birth is not imminent, it would be helpful to have a recommendation about use of lithotomy position and that staff should consider women's preferences. It can make people feel really vulnerable, although some will find the position helpful.	Thank you for your comment. The lithotomy position would fall under the advice 'any position she finds comfortable' and so could be chosen or declined by the woman.
University Hospital Southampton NHS Foundation Trust	Guideline	058	021	Need a recommendation on discussion of benefits and risks of caesarean if assisted vaginal birth is declined. Hopefully these conversations will happen before labour but not always.	Thank you for your comment. The committee has added an additional recommendation to this section to provide advice on the options if a women declines an assisted birth.
University Hospitals Plymouth NHS Trust	Evidence review G	007	002	Putting semi recumbent, lithotomy and lateral grouped together is disappointing when evidence shows that lateral is a good position to improve success of SVB (spontaneous vaginal birth) in the Bumpes study. Whereas lithotomy is discouraged for SVB (Elvander 2014) with increased rates of OASI . Some countries now discourage the use of lithotomy (and forceps) due to their increased risk of trauma Gyhagen 2021. With improved understanding of biomechanics midwives can	Thank you for your comment. The committee decided during the formulation of the review protocol that all positions of birth should be considered in our evidence review. However, studies with different classifications of positions of birth have not been pooled in our analysis. The 2 included studies in the evidence review (BUMPES 2017 and Golara 2002) have been analysed separately (not pooled) as the positions of birth were defined/classified differently in these studies. In BUMPES 2017,

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				encourage women into positions that open the pelvic outlet more effectively than lithotomy ie. knees shut, ankles apart.	women in the upright group were encouraged to adopt any upright positions during the passive and active phases of the 2nd stage of labour and women in the recumbent group were encouraged to lie on their side (left or right lateral) during 2nd stage of labour until birth. In Golara 2002, women in the upright group were encouraged to remain ambulatory during the passive 2nd stage of labour and women in the recumbent group were asked to remain in bed or in a chair during for as much of the passive 2nd stage as possible. Furthermore, Golara 2002 did not consider position of birth in the active pushing phase of the second stage. We did not identify evidence for lithotomy in our evidence review.
University Hospitals Plymouth NHS Trust	Evidence review H	006	006	Pushing techniques- we welcome the recognition of encouraging delayed, spontaneous, open glottis pushing as per new guideline.	Thank you for your comment.
University Hospitals Plymouth NHS Trust	Evidence review I	006	019	Table 1: Summary of the protocol – Episiotomy is listed in the PICO table as a critical outcome in the review of perineal care interventions to reduce perineal trauma and tears, yet the introduction to the evidence review (page 6) already acknowledges the benefit of episiotomy in reducing the risk of tear formation. Episiotomy may be better	Thank you for your comment. The protocols for the evidence reviews are agreed in advance of the review and when designing the protocol for this review the committee agreed that, when looking at less invasive perineal interventions, it would be useful to know if they reduced the risk of more invasive perineal interventions such as episiotomy. So, in this

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				categorised as an intervention or control rather than an outcome in the PICO table. While it is not recommended as routine, nonetheless it is used to prevent severe perineal trauma and aid birth where clinically indicated. Non-randomised studies that have shown it can prevent severe perineal trauma are not included in this evidence review. The categorisation of episiotomy as a critical outcome thereafter introduces bias into the evidence review of perineal care techniques because it fails to account for its benefits in an individual case or for specific types of birth ie. forceps We would also question the categorisation of first- and second-degree tears as critical outcomes in a review of techniques to prevent perineal trauma. While they are important outcomes, third- and fourth-degree tears are associated with the highest morbidity and long-term consequences. Similarly, while urinary incontinence in the first year after birth is deemed an important outcome, faecal incontinence after birth is neither listed as important or critical despite this being a more serious consequence of perineal trauma in childbirth.	context, although episiotomy is an intervention, the committee included it as an outcome. However, you are correct that in some cases carrying out an episiotomy could be beneficial if it prevented a serious tear, but the reporting of the evidence did not allow this level of detail to be determined. The committee were interested in all types of tears (first degree to fourth degree) and so included them all in the protocol, although they took into account when reviewing the evidence that third and fourth degree tears would more be serious for the woman. Thank you for highlighting faecal incontinence as an outcome of importance. The outcome of faecal incontinence in the first year after birth has now been added into the review as an important outcome alongside urinary incontinence, although no differences were found between any of the comparisons for which this outcome was available so it did not lead to any changes in the recommendations.

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University Hospitals Plymouth NHS Trust	Evidence review I	007	009 – 011	Included studies – UHP are concerned that only three randomised controlled trials (RCT) were reviewed to determine the effectiveness of 'hands on' support, otherwise known as manual perineal protection or MPP, in reducing perineal trauma. Of those three RCTs, two (McCandlish et al. and Mayerhofer et al.) were not designed with the primary aim of assessing the impact of MPP on third- and fourth-degree tears, whereas the third (Califano 2022) was not adequately powered to determine an intervention effect, nor reflective of circumstances such as induction of labour and instrumental births. Aside from these flaws, there is also an inconsistent application of MPP across the three studies, with 'hands on' being used at the time of delivery of the head and not necessarily the shoulders. For example, in the studies by McCandlish et al. and Mayerhofer et al., 'hands off/poised' meant that the hand was not applied to the perineum or infant's head until the head was born. In McCandlish et al., however, manual assistance for the birth of the shoulders was not provided, whereas in the study by Mayerhofer et al., no distinction was made between 'hands on' and 'hands off' for the assistance of the birth of the shoulders. This	Thank you for your comment. The evidence that the hands on / hands poised technique recommendation was based on has been revisited by the committee and in the light of the quality ratings of very low to low quality this recommendation has been removed.

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				is relevant because third- and fourth-degree tears can occur as the shoulders deliver. 'Hands on' vs 'hands poised' while the head is crowning also means differing things in each study. Emphasis of 'hands on' description being, 'pressure to keep baby's head flexed', other hand 'against' perineum or to 'support' the perineum. 'Hands poised' meaning hands ready incase they need to be applied only 70% compliance in Mc Candish. Vs the Finnish technique with MPP for head and shoulder described in Obstetric Anal Sphincter Injury (OASI) 1 & 2. Even calling this the Finnish technique needs explanation as this can be wrongly interpreted as Ritgens manover. The Finnish technique involves application of the thumb and index finger of the dominant hand on the perineal, while the flexed middle and remaining fingers are used to apply pressure against the perineal body. While, the non-dominant hand has light pressure on the fetal head to 'feel' the strength of the expulsive effort. This is continued until posterior shoulder has delivered. As this demonstrates 'hands on' and 'hands poised' can mean very different things. Despite the lack of quality RCT evidence to	

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				draw upon, something that NICE has acknowledged in its review by grading the three studies as of low to very low quality, their findings are being utilised to produce an updated recommendation on the effect of MPP and therefore inform future clinical practice.	
University Hospitals Plymouth NHS Trust	Evidence review I	011	024	Perineal massage in second stage- no women's feedback in highly invasive technique. We ask you to remove this recommendation and replace with antenatal perineal massage.	Thank you for your comment. Women's experience of labour and birth was included in the protocol as an important outcome but has not been reported for perineal massage as there was no evidence available from the included studies for this outcome. The committee noted that perineal massage is simple procedure, however some women may find it invasive to have it done during labour whilst experiencing contractions. Based on the evidence and committee experience, they agreed to recommend perineal massage as an alternative to a warm compress if women prefer it. This is discussed in the committee's discussion of the evidence. We are aware that perineal massage can also be carried out antenatally, but that was not within the scope of the intrapartum care guideline and so the evidence was not reviewed.
University Hospitals	Evidence review I	012	011 - 015	The qualitative evaluation of the OASI1 project (2016-18) sought to understand	Thank you for your comment and for informing us about this evaluation of the OASI project.

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Plymouth NHS Trust				women's experiences of labour and birth, including their experiences of 'hands on' support (see reference below). While only a small sample of 19 women were interviewed, their feedback provides valuable insight, something that the OASI2 study (2021-23) has sought to expand upon in its evaluation of women's experiences by interviewing a cohort of ca. 1200 women for the same purpose. The OASI2 evaluation is currently underway with publication expected in late 2023. Bidwell P, et al. Women's experiences of the OASI Care Bundle; a package of care to reduce severe perineal trauma (2021)	Details of this study have been passed to the NICE surveillance team who monitor guidelines to ensure that they are up to date.
University Hospitals Plymouth NHS Trust	Evidence review I	013	017 - 026	None of the RCTs on intrapartum perineal massage were powered for OASI. Stamp 2001 showed reduction in OASI but underpowered, Albers 2005 showed no difference between arms, Harlev 2013 compared types of oil/wax to use not that second stage perineal massage actually reduced tearing.	Thank you for your comment. The quality of each outcome in a NICE evidence review is assessed following GRADE processes taking into account risk of bias of the individual studies, the inconsistency, imprecision and indirectness. The evidence for perineal massage was graded low to very low, and the committee took this into account when making their recommendations, and made only a weaker 'consider' recommendation for massage, as an alternative for woman who preferred it to a warm compress (for which there was better evidence).

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University Hospitals Plymouth NHS Trust	Evidence review I	015	005 - 010	During its development in 2014, the RCOG and RCM did not include warm compresses as one of the components of the OASI Care Bundle as at the time there existed wide variation in practice, whereas the care bundle aimed to introduce a standardised set of practices that could be applied consistently. , We fully acknowledge the evidence that warm compresses can reduce the risk of severe perineal trauma and encourage their use by midwives and obstetricians independently of or alongside the OASI Care Bundle. OASI2(the implementation study in 2020-23) has promoted additional perineal care techniques such as warm compresses and antenatal perineal massage in its antenatal discussion guide for women, conference talks and teaching materials for clinicians as part of a range of practices women can choose as part of their birth plan to reduce third- and fourth-degree tears. We would contend that interventions such as 'hands on' (manual perineal protection) should not be considered in isolation but always as part of a combination of interventions that can be implemented together because the causes of third- and fourth-degree tears are complex. The US	Thank you for your comment and your support for the recommendation for warm compresses. The evidence that the hands on hands poised technique recommendation was based on has been revisited by the committee and in the light of the quality ratings of very low to low quality this recommendation has been removed. The committee recognised that the other aspects of the OASI care bundle include guidance on episiotomy angles and rectal examination, and that these aspects were also covered in the intrapartum care guideline so they made minor editorial amendments to the recommendations on rectal examination.

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				Institute for Healthcare Improvement (IHI) defines a care bundle as a small set of evidence-based interventions for a defined patient segment or population and care setting that, when implemented together, will likely result in better outcomes than when implemented individually. The development and implementation of the OASI Care Bundle was supported by the two principal national professional bodies representing maternity professionals and encouraged multidisciplinary teams to work together. The intervention was multifaceted and informed by a detailed theory of change, with women involved in all stages of the project to ensure that the implementation of the care bundle supported women's choice of birth position and the importance of communication during labour. The project team evaluated the OASI Care Bundle for clinical effectiveness as well as barriers and enablers to uptake. The clinical results, published in BJOG, compared almost 28,000 singleton vaginal births that took place before implementation of the care bundle with 27,000 singleton vaginal births that took place after. The evaluation found	

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				that the care bundle reduced OASI rates (third- and fourth-degree tears) from 3.3% to 3.0%, without affecting rates of caesarean birth or episiotomy. Despite this small percentage reduction of detected OASI**,** the care bundle was associated with a 20% *reduction in OASI risk* when individual characteristics, such as age, ethnicity, body mass index, parity, birthweight and mode of birth were taken into account.	
University Hospitals Plymouth NHS Trust	Guideline			Antenatal discussion was based on women's feedback that they wanted more information.	Thank you for your comment. We agree that the expanded section on antenatal information should help meet women's needs for information.
University Hospitals Plymouth NHS Trust	Guideline	051	018	Position in second stage- encouraging upright position and women to choose one they find comfortable is a welcome addition for the guideline.	Thank you for your comment.
University Hospitals Plymouth NHS Trust	Guideline	052	005	1-9-7 Pushing techniques- encouraging open glottis and spontaneous pushing in women without an epidural is welcomed	Thank you for your comment.
University Hospitals Plymouth NHS Trust	Guideline	052	005	Pushing techniques- clearly defining the passive from active second stage and lengthening it is welcomed. This will reduce the number of unneeded instrumentals for 'prolonged second stage'.	Thank you for your comment.

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University Hospitals Plymouth NHS Trust	Guideline	052	013	1-9-9 Positive that delayed pushing for primips with epidural is up to 2hrs.	Thank you for your comment.
University Hospitals Plymouth NHS Trust	Guideline	053	007	1-9-13. Warm Compress- we are delighted this has been included within the updated guideline and will improve it's uptake around the UK	Thank you for your comment.
University Hospitals Plymouth NHS Trust	Guideline	053	011	1-9-14. Massage in second stage as an alternative to warm compress. These 2 techniques should not be offered like they have the same balance of acceptability to women and research to evidence both techniques to reduce trauma equally. Antenatal perineal massage from 34 weeks to reduce perineal trauma is the more appropriate recommendation. This well evidenced technique to improve intact perineum, reduce OASI and episiotomy, improve wound healing and postnatal pain is also led by woman rather than the clinician. This lower emotionally charged and physically intensive environment while being self led will reduce the impact of such an invasive technique. Beckmann & Stock Cochrane review 2013, Abedelhakim 2020	Thank you for your comment. Massage is not offered as an equal alternative - it is considered in women who prefer it to the warm compress - so would only be used if acceptable to the woman, and this has been added to the recommendation. The evidence was reviewed only for use of intrapartum massage, not in the antenatal period, so no recommendations for antenatal use have been made.
University Hospitals	Guideline	053	014	Rec 1.9.15 – We are concerned that this updated recommendation is based on a	Thank you for your comment. The committee reviewed the evidence for hand position again,

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Plymouth NHS Trust				limited review of low quality evidence on interventions to reduce perineal trauma and a miscategorisation of episiotomy as only a harmful outcome rather than an intervention that can help to prevent severe perineal trauma (see rationale in subsequent comments).	and as it was low quality they agreed it was insufficient to provide guidance on the best hand position and so have removed this recommendation and instead just made a research recommendation.
University Hospitals Plymouth NHS Trust	Guideline	167		Instrumental/forceps birth could have been added to the inclusion criteria when screening the data as it's an important risk factor for OASI.	Thank you for your comment. As there are no recommendations on page 167 relating to OASI we are not sure what your comment relates to.
University Hospitals Plymouth NHS Trust	Methods	011	013 - 017	Types of studies and inclusion/exclusion criteria – Given the lack of high quality evidence available from randomised controlled trials (RCT) on the effect of 'hands on' support, otherwise known as manual perineal protection or MPP, UHP is unsure as to why NICE has not expanded its inclusion criteria to accommodate the best available evidence from non-randomised studies (NRS). Several non-randomised studies, particularly from Scandinavia, have shown a significant reduction in the risk of third- and fourth-degree tears when MPP is applied, including those reviewed in Bulchandani et al (2015) as well as the clinical outcomes from the OASI1 project led by the RCOG and RCM. These	Thank you for your comment. The aim of the NICE evidence review on perineal care was to identify the benefits or harms of individual interventions (for example warm compresses or hands on care) and this is best achieved using randomised controlled trials. The studies you are referring to, including the outcomes from the OASI project, assess the results from using a bundle of interventions. While the 'bundle' seems to improve care it is not known which of the included interventions has the best effect, or if one intervention is actually causing harm but is being balanced out by the beneficial effects of other interventions.

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				NRS have all tested intervention programmes that include not just MPP but also other practices to support a guided birth and reduced severe perineal trauma. These practices include; antenatal discussion to improving pelvic health and reducing severe tears, good communication between the accoucheur and the birthing woman to enable a slow and guided birth, , improved skills of the use of episiotomy if clinically indicated, MPP and systematic examination of the vagina and ano-rectum to detect any tears after birth. All with the woman's consent. Therefore, we believe that MPP should not be considered in isolation but as part of a series of coordinated interventions that take place during the final moments of childbirth.	
Western Health and Social Care Trust	Guideline	008	017	Can this emphasise that there need to be appropriate staff trained in water birth, pool availability is on only one element of providing water birth services.	Thank you for your comment. This recommendation has not been amended as the use of birthing pools was not included as part of this update. However, updating the recommendations on use of birthing pools has already been prioritised by NICE when the ongoing POOL study has published and your comments will be considered as part of this update. Please see: https://www.nice.org.uk/guidance/cg190/resources/2023-exceptional-surveillance-of-intrapartum-care-for-healthy-women-and-

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					babies-nice-guideline-cg190-11443418173/chapter/Surveillance-decision?tab=evidence#planning-place-of-birth
Western Health and Social Care Trust	Guideline	010	003	Table 2 How is it possible to provide evidence for women with a BMI between 25-35 if there is no data available , is there any reason to include this within the table, how do we know it this is even a risk for stillbirth.	Thank you for your comment. In response to stakeholder feedback the committee agreed that that although risks seem to increase with an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail. The composite outcomes are as reported in the studies, but more detail for some single neonatal outcomes is included in the GRADE tables in evidence review A.
Western Health and Social Care Trust	Guideline	011	004	Table 4 There is no data to support transfer rate for BMI 25-29.9	Thank you for your comment. In response to stakeholder feedback the committee agreed that that although risks seem to increase with an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this.

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Western Health and Social Care Trust	Guideline	012	003	Table 5 No data to support informed choice in 3 different BMI 25,30,35 this lack of evidence does not provide informed choice , why is this included in the table	Thank you for your comment. In response to stakeholder feedback the committee agreed that that although risks seem to increase with an increase in BMI at booking, the main increase in risks is seen at a BMI more than 35 kg/m^2 and so the recommendation has been amended to state this. We have amended the summary tables to clarify comparisons where there is no data and where there is no difference, but as the tables are so complicated we have included more detail in the wording of the recommendation and moved the tables to appendix B, where they are available for people who would like to look at this level of detail.
Western Health and Social Care Trust	Guideline	016	027	Table 10 The wording of title 'suggest' this is subjective and interpretive can this be reconsidered to something which provides more clarity.	Thank you for your comment. The title of this table is designed to indicate that healthcare professionals and women should review this information and make an informed decision about the most appropriate place of birth on an individual basis. It is not designed to mandate that particular conditions always require birth in an obstetric unit.
Western Health and Social Care Trust	Guideline	017	002	Table 11 Same wording 'suggesting' used again subjective and interpretive can this be reconsidered to wording which provides more clarity	Thank you for your comment. The title of this table is designed to indicate that healthcare professionals and women should review this information and make an informed decision about the most appropriate place of birth on an

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					individual basis. It is not designed to mandate that particular conditions always require birth in an obstetric unit.
Western Health and Social Care Trust	Guideline	018	002	Table 12 Individual assessment needed, can more emphasis be placed on making a personalised plan of care to facilitate the assessment process and women's choice	Thank you for your comment. The recommendation above this table which refers to its use already advises that the information should be used in discussions with the woman so she can make an informed choice about the planned place of birth.
Western Health and Social Care Trust	Guideline	019	002	Table 13 The word 'consider' again lacks clarity or direction/guidance for care providers, this suggests that to consider is adequate and no action is required further to consideration.	Thank you for your comment. The title of this table is designed to indicate that healthcare professionals and women should review this information and make an informed decision about the most appropriate place of birth on an individual basis. It is not designed to mandate that particular factors always require birth in a particular location.
Western Health and Social Care Trust	Guideline	019	002	Table 12 Non pharmacological induction of labour eg mechanical – can this clarify is these inductions are suitable for low risk care in labour, in the absence of any other risk factors	Thank you for your comment. Mechanical and pharmacological methods of induction may be available on midwife units in some locations but not others, and therefore this would need to be taken into consideration when planning place of birth, hence it is included in this table as a factor to consider.
Western Health and Social Care Trust	Guideline	026	022	Can this clarify which care provider can administer these injections eg midwife/obstetric/anaesthetic	Thank you for your comment. The recommendation has been clarified to state that suitably trained midwives can administer sterile water injections.

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Western Health and Social Care Trust	Guideline	048	025	Can clarity be provided about the correct interval for starting oxytocin in the second stage of labour e.g. after delivery of first twin.	Thank you for your comment. There is advice in the section of the guideline on the second stage of labour about starting and increasing the dose of oxytocin, but this does not include the delivery of twins, as multiple births are not within the scope of this guideline.