National Institute for Health and Clinical Excellence

Clinical guideline: Caesarean section (update)

PRE-PUBLICATION CHECK ERROR TABLE

Number	Organisation	Order number	Section number in FULL guideline	Page number	ERROR REPORT	Response
1.	Birth Trauma Association	1	Summary	25	Inform women who have had up to and including four CS that the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and that uterine rupture is very rare. **[new 2011]** I am sorry if the following seems pedantic but I think it is important to get this right because VBAC is a CNST hotspot and it will inevitably be used in litigation. The meaning of words needs to be precise. The proposed sentence is linguistically incorrect, isn't it? The second clause needs to include a subordinate clause otherwise you are saying there is no connection between the two bits of information. Surely you should say: " uterine rupture, although higher for planned vaginal birth, is very rare." (A silly example to illustrate this rule would be "Inform women who have had up to four CS that the risk of fever etc does not vary with planned mode of birth and Wales is full of sheep" This is correct if you intend to give	Thank you for your helpful comment. We have amended the recommendation as you suggest so that it now says "…uterine rupture, although higher for planned vaginal birth, is rare". We recognise that the Green Top guidance currently gives a figure for the absolute risk for uterine rupture. The guideline development group felt that as the risks for uterine rupture are low, it was not necessary to specifically indicate them in the recommendation. Rather, there should be an individualised discussion with the woman which includes reference to the risks and benefits of both CS and VBAC (recommendation 119), including uterine rupture.

					women those two separate and unconnected bits of information one about the sheep and one about the CS risks. If the information is connected you should use a subordinate clause to identify the connection – miss it out and you are implying no connection.) Also is 22-74 per 10,000 classified as a very rare risk? Has that been checked? I thought the classification for that magnitude of risk falls between 'uncommon' and 'rare'. (I think there is NHS guidance on communicating risk). Also the Green Top says this : "Women considering the options for birth after a previous caesarean should be informed that planned VBAC carries a risk of uterine rupture of 22–74/10,000. There is virtually no risk of uterine rupture in women undergoing ERCS". You can't have two lots of guidance saying opposite things☺	
2.	Birth Trauma Association	2	4	62	Neonatal mortality seems to be listed twice with slightly different text.	Thank you for your comment. The second instance of neonatal mortality should have been listed under a sub-heading indicating that the outcome was for neonates born to women with a BMI of ≥ 50. The document has now been amended accordingly.
3.	Birth Trauma Association	3	4	62	NICU admission is listed twice again with different text. The second text says that when adjusted for gestation this was not statistically	Thank you for your comment. The second instance of NICU admission should have been listed under a sub-heading indicating that the

					significant. If so, should it be in the 'reduced after vaginal birth' section on page 8 as UK sections are normally at 39 weeks which would not normally require SCBU admission.	outcome was for neonates born to women with a BMI of ≥ 50. The document has now been amended accordingly. As these findings were for a specific sub-group, they have not been included in the summary comparison table.
4.	Birth Trauma Association	4	13	220 212	**There seems to be an error in the H/E "**The drivers of this are the increased relative risk of hysterectomy and neonatal mortality with maternal request caesarean section." Where does the increased neonatal mortality come from? That is not what the guideline has concluded – the evidence was conflicting. There are other outcomes listed on page 212 also which were not conclusively shown to favour VB or CS so why are they in the economics appraisal?	Thank you for your comment. This is not an error. The neonatal mortality figures used in the model are given in Table 13.15. These data are taken from the MacDorman 2008 (page 58) and the rationale for using that study was given on p210; "The outcomes are limited to those for which there was reported data in the review, which focused on outcome by planned, as opposed to actual mode of birth. For some of these outcomes results from more than one study were presented. However, it wasn't reasonable to pool results from these studies and in such cases the model used the risk from the largest study. Whilst this provides a consistent approach it doesn't necessarily mean that the bigger study estimated the true risk more accurately. Sensitivity analysis could be used to test whether using estimates based on other studies made important changes to the model outcome." Probabilistic sensitivity analysis factors reflect sampling error (in an analogous way to the methods used for determining statistical significance) without excluding data based on arbitrary cut-offs of statistical significance. The outcomes shown in Figure 13.12 are based on sampling from the probability distributions of the risk of all outcomes listed on p212 and the fact that there may not be statistically significant differences between these outcomes does not make the approach invalid.
5.	British HIV Association (BHIVA)	1	5.8	86	We do not agree with the recommendation that women co-infected with HIV and Hepatitis C should have a CS.	Thank you for your comment. The topic of women co-infected with HIV and Hepatitis C was not identified as a priority area for update

					HIV and HCV co-infection is associated with a significant increase in HCV transmission (OR up to 2.82) compared to HCV mono-infection (Pappalardo, Polis, European network). In addition a higher rate of MTCT is seen in mothers who are co-infected and HCV viraemic compared to those who are co-infected and non-viraemic (OR 2.82) as well as to HCV viraemic but HIV-negative (OR 1.97). Numerous studies have shown that the degree of HCV viraemia correlates with the risk of MTCT and it is likely there is a linear relationship between VL and transmission (Ngo, Roberts) as for HIV. Effective HAART significantly reduces the rate of HCV transmission, possibly by reducing HCV viraemia (EPHN 2005, England). In the first European Paediatric Hepatitis Network cohort, a subgroup analysis of women co-infected with HIV (n = 503, 35.4%) demonstrated a reduced risk of vertical transmission of HCV with C/S (OR 0.43, 95% CI 0.23 to 0.80) (EPHN 2001). However in a later analysis from EPHN (n=208 15.0%), no such association was found (OR 0.76 CI 0.23–2.53) (EPHN 2005). In the later analysis, MTCT of HCV was less (8.7% vs. 13.9%) and more women probably received CART (41%) which was associated with a significant HCV viral load reduction compared to those who received monotherapy or no therapy (OR 0.26 (0.07–1.01)). There was also a trend to lower HCV viral load in this group which may go some way to explaining this. Also, in a small French cohort of co-infected women (29% on HAART), rate of transmission did not differ significantly between children born by vaginal delivery or C/S (ALHICE). Therefore, the BHIVA HIV Pregnancy Guidelines Writing Group do not feel that the available data on HCV transmission in women on CART supports the recommendation of a caesarean section for women co-infected with HIV and HCV. Rather, all co-infected women should be treated with CART in pregnancy and mode of delivery	when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update.

					should be determined by HIV viral load	
6.	British HIV Association (BHIVA)	2	5.8	85	With regard to the optimal mode of delivery for HIV infected women, we have reviewed the data on the efficacy of Pre-Labour, Pre-Rupture of membranes Caesarian section (PLCS) at viral loads <400 HIV RNA copies/ml plasma. We note that reporting of viral loads at delivery has been very variable according to the cut-off of different assays over time. The current viral load cut-off is generally reported at <50 and from the NSHPC there are now robust data of an absence of benefit with PLCS in mothers on CART with viral loads <50. Some reports present data showing very low rates of transmission in women with a viral load of <400 regardless of mode of delivery. Since in the majority of women the viral load was likely to be less than 50 but the lower detection limit of the assay was 400 the question of the efficacy of PLCS at viral loads 50 – 399 cannot be addressed from the published data. We have therefore sourced from two major cohorts more recent data relating to measured viral loads between 50 and 399 and HIV transmission rates according to mode of delivery. Although the numbers are too small to reach statistical significance the data from each cohort are remarkably similar showing a 1% higher transmission rate with deliveries that were not PLCS compared with those that were. However these data are unpublished. If one considers only the published data, based on our concerns regarding the true numerical value of the viral loads in women reported as having a viral load of <400, we do not feel that there are sufficient published data to change the recommendation we made in the 2008 BHIVA Pregnancy guidelines that women with a viral load of >50c/ml should have a PLCS. However, based on the additional unpublished data outlined above, our conclusion is that in women with a viral load of 50 to 399, a PLCS should be considered, and above 400c/ml it should be recommended.	Thank you for your comment. The group's recommendations were based on the available evidence, their own clinical expertise and experience and advice from an external expert. It was not felt necessary to make further changes to the recommendations at this stage, particularly as the unpublished data which you highlight seem to support the GDG's position and the recommendations made.

7.	Csections.org	1	5.9	100 line 41	Please could you clarify that only '**some**' of the downstream costs have been included in the analysis. While it does go on to say this later, it should be clarified at this point as the cost savings are likely to have been even lower if all downstream costs had been included, not just those in the review.	Thank you for your comment. The reference to downstream costs here has been used to indicate to the reader that the scope of the cost goes beyond that of the immediate birth event. As you recognise, the next paragraph highlights that the analysis does not consider all downstream costs. We feel that this is clear and so have not amended the document.
8.	Csections.org	2	5.9	100 line 42	Opening sentence is contradictory. Should it be 'found' or 'did not find'.	Thank you for your comment. The use of the word 'found' is correct here and we do not see a contradiction
9.	Csections.org	3	5.9	100 line 45-6	This last sentence should be removed. Earlier and later statements within the same and subsequent paragraph shows that a sentence including the word 'dominated' is entirely misleading.	Thank you for your comment. The last sentence reflects the base case analysis and so is not factually incorrect. The concerns that you have about that finding are addressed in the next paragraph
10.	Csections.org	4	5.9	101 line 40	Extra fullstop.	Thank you for your comment. This typo has now been corrected.
11.	Csections.org	5	11.2	191 line 9	Please could you clarify that only '**some**' of the downstream costs have been included in the analysis.	Thank you for your comment. The sentence starts "In addition to the costs of birth the model also **estimated** 'downstream' costs". This describes the methodological approach to costing. What was included is described on pages 210-212 and a cost was estimated for **all** adverse outcomes included in the base case analysis. In the sensitivity analysis which included urinary incontinence, a "downstream" cost for this was also included.
12.	Csections.org	6	13.3	204 line 26	Please could you clarify that only '**some**' of the adverse events and downstream costs have been included in the analysis.	The term "downstream" here is being used in a conceptual sense to indicate that economic evaluation shouldn't be limited to the immediate costs of the intervention (in this case a diagnostic technique for morbidly adherent placenta). The GDG believed that

						"being prepared" for morbidly adherent placenta could improve outcomes for mother and/or baby although the clinical review did not identify any evidence of a relationship between a diagnosis of morbidly adherent placenta and patient outcomes. Therefore, the model took a "what-if" approach to "downstream" costs arising from, adverse outcomes (Figures 13.4 and Figure 13.5)
13.	Csections.org	7	13.3	207 line 10	Should one of these (namely the part referring to £2,369 be 'actual planned caesarean' and not 'planned vaginal birth'?	Thank you for your comment. You are correct that the text should refer to actual planned caesarean and it has been amended accordingly.
14.	Csections.org	8	13.3	207 line 15	I would like it noted that I cannot believe that the cost analysis continues to base its findings on a figure which includes those caesareans where there are obstetric implications!! This renders the entire analysis significantly flawed.	Thank you for your comment. This point does not address a factual error in the document and so cannot be further addressed here.
15.	Csections.org	9	13.3	213	I would like it noted that the number of 'outcomes' for which there was no QUALY data is significant and that as a result the findings based on the costs and QUALY ratings must therefore be questionable, particularly given that a number of these ungraded 'outcomes' are likely to impact upon the more long term emotional outcome for the woman and her on-going perception of her birth – which in turn is likely to have knock on effect on her voluntary fertility.	Thank you for your comment. This point does not address a factual error in the document and so cannot be further addressed here.
16.	Csections.org	10	13.3	219 line 27	I am very concerned that the use of the 5.6 million saving is reiterated in this particular section (maternal request evaluation), despite the fact that throughout the guideline this figure is caveated to the extent that it is quite clear that such savings are unlikely if all downstream costs and QUALY's are included. Added to which the guideline clearly states (pg 207) that the cost used in the cost assessment include those caesareans which have 'obstetric implications' (simply because there is no better data). This section is a significant one likely to be read by the media (indeed has already been so and is	Thank you for your comment. The figure (which has now been amended to £4.9 million) is based on the base case analysis which includes some of the 'downstream' costs. Subsequent paragraphs in this section provide further clarification for the findings and highlight the caveats that need to be considered. We feel that the current wording is appropriate and does not need to be changed.

					already being used as justification for those opposing 'informed choice' blaming the caesarean rate on women 'too posh to push'). The media are notorious for not checking the detail and will fail to appreciate the implications for the cost difference of only including certain downstream costs etc. I would prefer that this figure be removed from the discussion or should this not be possible it should be clearly and heavily caveated in the subsequent sentence to show that such savings are not actually realistic. Something along the lines of "it is highly likely that …" rather than the current sentence on line 29 that it is 'possible'.	
17.	Csections.org	11	13.3	219 line 35	I would like it noted that I am vehemently opposed to the statement in this discussion that vaginal birth is cheaper than maternal request caesarean when you have already admitted that the caesarean figures automatically include 'obstetric implications' and that you have no meaningful figures to use as maternal request alone (see comments in previous point – 11).	Thank you for your comment. This point does not address a factual error in the document and so cannot be further addressed here.
18.	Csections.org	12	13.3	219 line 36	How can the following sentence remain "In a publically funded…" when you have said that the inclusion of relevant outcomes would 'reduce' the discrepancy?	Thank you for your comment. This section was discussing the base case analysis, the results of which could be used to justify a decision not to make caesarean section available solely on the grounds of maternal request. However, the guideline was not restricted to the base case analysis and the results of the sensitivity analyses are also discussed.
19.	electivecesarean.com	1	13.10	207	"The cost of method of birth", immediately after Figure 13.10 Lines 12 and 13 read: "For example, it is estimated that 10% of planned vaginal births will result in an unplanned caesarean section." Yet in the "Consultation table with responses", no. 371, re: *'Proportion of actual modes of birth*	Thank you for your helpful comment. You are correct that this should now read "15%" and the text has been amended accordingly.

					for planned VB and CS birth', in section 13.10, the Developer's response says, "Thank you for your comment. The uncertainty around this input was addressed in sensitivity analysis (see Figure 13.14 in the consultation version of the full guideline). You do not provide a reference for your —correct figure and to the best of our knowledge data is not routinely collected on planned mode of delivery. However, based on suggestions from another stakeholder comment, we accept that HES/ONS data probably allows for a more accurate estimate and the model and text has been changed accordingly." Therefore, I think that the sentence on lines 12 and 13 should now state the figure 15% instead of 10%.	
20.	electivecesarean.com	2	13	215	"Results" (lines 13-17), immediately after Table 13.16 Could you please check the statement that reads: "The base case result suggests that the birth cost of a planned vaginal birth is £800 cheaper than a planned caesarean section. For an annual birth rate of 706,000 (ONS) this might suggest that approximately £5.6 million could be saved for every one percentage point reduction in caesarean section rate, providing that the change occurred in a population similar to that used in this model." But Table 13.7 no longer shows £787 as the Incremental cost – it shows £710. Therefore, I think the sentence should read:	Thank you for your comment. You are correct that the figures of £800 and £5.6 million are wrong and these have now been amended accordingly.

					"The base case result suggests that the birth cost of a planned vaginal birth is **£700** cheaper than a planned caesarean section. For an annual birth rate of 706,000 (ONS) this might suggest that approximately **£4.9 million** could be saved for every one percentage point reduction in caesarean section rate…"	
21.	electivecesarean.com	3	13	219	"Discussion" (line 27), immediately after Table 13.19 This still reads £5.6 million, but if the GDG agrees that the £4.9 million figure noted in no. 2 above is correct, this would need to be changed here too.	Thank you for your helpful comment. You are correct that this figure is wrong and it has been amended accordingly.
22.	electivecesarean.com	4	5.9	100	Health Economics (lines 42 & 43) Again, this states that **"**a planned vaginal birth was approximately £800 cheaper than a maternal request caesarean section. This implies that the NHS could save £5.6 million**"** If the revised figures noted in no. 2 above are agreed as being correct, this should read: **"…**a planned vaginal birth was approximately £700 cheaper than a maternal request caesarean section. This implies that the NHS could save £4.9 million".	Thank you for your comment. You are correct that the figures of £800 and £5.6 million are wrong and these have now been amended accordingly.
23.	electivecesarean.com	5	5.9 & 13	100 & 215	Regarding the statements:	Thank you for your comment. We believe the qualification is sufficient and is made to indicate that those savings would not necessarily apply from a reduction in

					1) "This implies that the NHS could save £5.6 million for every percentage point reduction in caesarean section if the characteristics of the population were similar to those of women included within the guideline model." (p.100) 2) "The base case result suggests that the birth cost of a planned vaginal birth is £800 cheaper than a planned caesarean section. For an annual birth rate of 706,000 (ONS) this might suggest that approximately £5.6 million could be saved for every one percentage point reduction in caesarean section rate, providing that the change occurred in a population similar to that used in this model." (p. 215) The GDG has qualified in each of these statements that the characteristics of the population of women would need to be similar, but I think that the adverse outcomes financially accounted for would need to be similar too. Therefore for greater accuracy, would the GDG please consider qualifying these statements by adding this caveat (or similar wording) too: "…**if the costs of outcomes accounted for were similar to those included in the guideline model**".	caesarean section more generally (i.e. in women for whom caesarean section is clearly indicated).
24.	electivecesarean.com	6	13	100	"Health Economics" (line 41) Re: the sentence, "The analysis considered both the costs of birth and "downstream" costs associated with the outcomes…"	Thank you for your comment. This sentence relates to methods and is used to indicate to the reader that the scope of the cost goes beyond that of the immediate birth event. What "downstream" costs have been included is given in greater detail in the health

					For this statement to be more accurate, would the GDG please consider the following (or similar) modification please: "The analysis considered both the costs of birth and **some/many of the** "downstream" costs associated with the outcomes…"	economics chapter.
25.	Ferring Pharmaceuticals	1	7.6	147	**The guideline is incorrect in saying that carbetocin is "yet to be launched". The product was launched in the UK in 2006.** **The Basic NHS price is £88.20 for 5 ampoules - £17.64 per ampoule (ref: MIMS Sept 2011).**	Thank you for your comment. The topic of the use of uterotonics was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update.
26.	Ferring Pharmaceuticals	2	7.6	147	**The proposed guideline highlights that trials of Carbetocin vs Oxytocin do not compare Carbetocin with the oxytocin dose recommended by NICE (5 IU).** **This is no longer the case because since the last NICE update one RCT and one observational study have been undertaken to help address this - Attilakos et al 2010 and Triopon 2010. Both had an arm that used 5 IU oxytocin bolus, the UK licensed dose and dose recommended by NICE. Therefore Ferring feel that, in order to reflect the accurate current data, the guideline should be corrected in line with the comments above.** **Attilakos *et al,* British Journal of Obstetrics and Gynaecology 2010 Jul;117(8):929-36 : 'Carbetocin versus oxytocin for the prevention of postpartum haemorrhage following caesarean section: the results of a double-blind randomised trial'**	Thank you for your comment. The topic of the use of uterotonics was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update.

					Triopon *et al* Gynécologie Obstétrique & Fertilité 2010 Dec;38(12):729-34. Use of carbetocin in prevention of uterine atony during caesarean section. Comparison with oxytocin **Ferring are aware of data from Holland from a set of 1751 patients in an observational study of carbetocin and various oxytocin dose regimens (including 5 IU bolus). This data is not published but Ferring would be more than willing to share this information – under a commercial, in confidence setting.** **We feel that whilst the guideline will be updated, for some sections it will still be out of date at the time of publication as it does not take into account these new clinical trials.**	
27.	Flynn Pharma	1	general	general	I am writing to enquire as to why the guideline authors did not consider any of the three directly relevant published studies presented in Flynn Pharma's previous comments to the CS Update team on 20th June 2011. In particular, two recent published studies documenting and reporting the use of Depodur (extended release epidural morphine sulfate) in practice. The evidential quality and robustness of these data and evidence in our view exceeds that on which the present advice relies in regard to pain management after CS. May we ask that NICE provide an explanation as to why this evidence has nor been considered and taken into account in formulating the update.	Thank you for your comment. Pain management was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update.
28.	Gloucestershire Hospitals NHS Foundation Trust	1	5.2	76	'In otherwise uncomplicated twin pregnancies at term where the presentation of the first twin is cephalic' should this not read: **'In an uncomplicated dichorionic twin pregnancy at term where the first twin is cephalic,**	Thank you for your comment. The topic of multiple pregnancy was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in this guideline update.

						Your comments will be taken into account when next reviewing this guideline for update.
29.	Gloucestershire Hospitals NHS Foundation Trust	2	6.1	105	**Ref 174.** The study re home births and rates of LSCS are from 1994. It would be helpful if there were a more up to date publication to support the assertion that home birth is not associated with an increase in the rate of LSCS.	Thank you for your comment. The topic of place of birth and its influence on CS was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update.
30.	Independent Midwives UK	1	general		Independent Midwives UK would like to suggest that Breech Presentation be removed from the LSCS box. It is of concern that breech presentation appears to be the primary reason for elective LSCS in the guidance when the evidence used to support this recommendation (1) has been widely criticized for the not running the full time, imposed restrictions, lacking homogeneity between participants and methodology. (2, 3, 4,5.) The follow-up papers of The Term Breech Trial (6, 7.) concluded that the trial had been ended too early to be conclusive as the findings of the follow-up research showed no statistical difference between the two groups for mothers or babies. In 2006 the results of a prospective study was published (8)[PREMODA study], having first been presented at the First International Breech Conference in Vancouver 2006, that showed that there was no statistical difference between planned vaginal delivery and LSCS for breech presenting babies, or their mothers. There is, increasingly, an acceptance that the skills for assisting women to birth breech presenting babies vaginally should be re-introduced as part of the normal training for both obstetricians and midwives, using the experience and knowledge of a few remaining practitioners, before the skill is lost (9). Vaginal delivery for breech presentation is currently being re-evaluated in the UK by National Institute for Health Research.	Thank you for your comment. Breech presentation was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update.

					The 2010 review of the evidence for the Cochrane Data Base found only one RCT that could be included. 3 other papers, two prospective studies, were mentioned but did not include the Goffinet study which may have introduced bias to the recommendations. The authors of the Cochrane review (10) were both involved in the Term Breech Trial (1). The Cochrane review is due to be updated again in 2012 and we have been assured by one of the authors that the Goffinet study will be included in their considerations. (Personal communication Hofmeyr, J. 2011) Independent Midwives UK would therefore like to see the N.I.C.E. guidance reflect the growing evidence against routine LSCS for women with breech presenting babies rather than using a piece of research, that has been identified as having serious flaws, as the evidence to support the N.I.C.E. guidance. We would suggest that the N.I.C.E. guidance support the option of safe vaginal breech birth using the skills already available which would ease the financial burden to the NHS of 3-4% of all pregnancies resulting in a LSCS. The guideline would remain evidence based and would give wider options to women who have a breech presenting baby. <u>Quote:-</u> 'But caesarean section cannot be the response to suboptimal care for vaginal breech birth. '	
31.	Independent Midwives UK	2	general		Independent Midwives UK would also like to express great concern over the recommendation to offer elective LSCS to women on request. We would suggest that one to one care with a named midwife throughout her pregnancy, birth and post partum period as a first choice for women who have a fear of vaginal delivery.	Thank you for your comment. The issue you raise is not a factual error and so cannot be addressed here.
32.	OAA	1	References	233	**Update to Ref 329 – Husain et al Int J Obstet Aneth 2005;14:14-21**	Thank you for your comment. The topic of the anaesthesia for CS was not identified as a

						priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update.
33.	Royal College of Nursing.	1	general		Nurses in the RCN's Midwifery and Fertility network were invited to carry out a pre-publication check on this guideline. They have indicated that they have not observed any factual errors and there are no further comments to make on the documents on behalf of the Royal College of Nursing.	Thank you
34.	The Royal College of Midwives (RCM)	1	1.3	8	Following discussion with XXXX about this, and reviewing and adjusting our comments limited to 2011 changes and areas we feel our concerns have not been addressed: 'If, after providing support, a vaginal birth is still not an acceptable option to the woman, offer a planned CS.' Although the RCM agrees that for some women who have had very difficult experiences, this is an appropriate recommendation, it is concerned that the complexity of the discussion and decision making is not adequately covered in the algorithm and the NICE guideline. The way this has been presented to date and the high profile the recommendation has had in press releases from NICE, seems to be simply encouraging CS. Many of our members have commented on this as very unhelpful in their quest to reduce CS rates, and say it will de-motivate practitioners and add to the pressure for CS.	Thank you for your comment. The group received a number of comments following the first stakeholder consultation process about this recommendation. Some amendments were made in light of those comments. Please note that this recommendation is one of a number that address this issue in order to address the complexity of the matter, in particular the various underlying reasons why a woman may request a CS. The guideline development group now feel that these recommendations, including the one you highlight, are appropriate given the clinical evidence, health economic evidence, the clinical expertise of the group and the stakeholder views.
35.	The Royal College of Midwives (RCM)	2	1.3	8	Following discussion with XXXX about this, and reviewing and adjusting our comments limited to 2011 changes and areas we feel our concerns have not been addressed: 'An obstetrician can decline….. carry out the CS).	Thank you for your comment. Please see our response to comment 496 of the 1st consultation table (available here: http://www.nice.org.uk/guidance/index.jsp?action=download&o=56260) where this issue has been addressed.

					The 2004 guidance was written more appropriately, offering the woman a second opinion which all women are entitled to. This statement implies there will always be one consultant within units who will offer CS for any indication..	
36.	The Royal College of Midwives (RCM)	3	1.3	8	Following discussion with XXXX about this, and reviewing and adjusting our comments limited to 2011 changes and areas we feel our concerns have not been addressed: This table is unclear, and appears biased (in favour of planned CS) and misleading because like is not compared with like. It would be clearer if the table columns were split into risks and benefits (RaB) of 1) elective CS, 2) emergency CS, 3) operative vaginal delivery, 4) spontaneous birth, with each column presenting a précis of key evidence of maternal and neonatal RaB, including areas where the evidence is conflicting.	Thank you for your comment. Please see our response to comment 48 of the 1st consultation table (available here: http://www.nice.org.uk/guidance/index.jsp?action=download&o=56260) where this issue has been addressed.
37.	The Royal College of Midwives (RCM)	4	1.3	10	Following discussion with XXXX about this, and reviewing and adjusting our comments limited to 2011 changes and areas we feel our concerns have not been addressed: Preoperative testing and preparation section, last sentence 'women having a CS under GA require at least an in/out catheter to ensure the bladder is empty - should be included here.	Thank you for your comment. Emptying of the bladder prior to CS was not identified as a priority area for update when the scope of the guideline was being developed. As a result, this topic has not been addressed in the guideline update. Your comments will be taken into account when next reviewing this guideline for update
38.	The Royal College of Midwives (RCM)	5	7.3	132	Following discussion with XXXX about this, and reviewing and adjusting our comments limited to 2011 changes and areas we feel our concerns have not been addressed: It is not clear why the audit of decision to delivery time should not be used to determine the effectiveness of the team. If the audit is not impacting on this, what is its purpose?	Thank you for your comment. Please see our response to comment 68 of the 1st consultation table (available here: http://www.nice.org.uk/guidance/index.jsp?action=download&o=56260) where this issue has been addressed.
39.	The Royal College of Midwives (RCM)	6	Appendix D	48	Following discussion with XXXX about this, and reviewing and adjusting our comments limited to 2011 changes and areas we feel our concerns have not been addressed:	Thank you for your comment. As there is now updated guidance on this topic in the induction of labour guideline, it was felt best to remove this recommendation from the guideline and include a cross-reference.

					We do no agree with the deletion of the recommendation on induction of labour here. It is relevant in both guidelines.	