National Institute for Health and Clinical Excellence

Antenatal care (update) guideline scope stakeholder consultation table

13 June – 10 July 2006

Stakeholder organisation	Section	Comments	Response
Academic Division of Midwifery, University of Nottingham		This organisation was approached but did not respond.	
Action on Pre-Eclampsia		This organisation was approached but did not respond.	
Addenbrookes NHS Trust		This organisation was approached but did not respond.	
Antenatal Screening Wales		This organisation was approached but did not respond.	
Association of Breastfeeding Mothers		The Association of Breastfeeding Mothers' wishes to express general comments regarding the NICE consultation on antenatal care	Thank you.
Association of Breastfeeding Mothers		1 The ABM recommends that NICE should tie in the AN care guidance with the post natal care guidance already drafted and make explicit the need for antenatal preparation for breastfeeding to become a maternity service standard	Thank you. Whilst recognising that breastfeeding is an important issue we are unable to address it within the time available for the current update.
Association of Breastfeeding Mothers		2 AN preparation for breastfeeding is currently mostly aimed at middle class professionals - more likely to attend NHS "parentcraft" sessions or more able to pay to attend classes provided by voluntary organisations	Thank you.
Association of Breastfeeding Mothers		3 AN preparation for breastfeeding as a maternity service standard should adhere to the best practice standards of the Unicef Baby Friendly Initiative and should be delivered in stages throughout pregnancy on an individual client basis.	Thank you.
Association of Breastfeeding Mothers		4 All health professionals involved in antenatal care should receive breastfeeding training appropriate to their level of clinical responsibility for an expectant mother	Thank you.
Association of Breastfeeding Mothers		5 AN preparation for breastfeeding should not depend on a woman's ability to attend or confidence to attend group sessions	Thank you.

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Birth Trauma Association		This organisation was approached but did not respond.	
British Dietetic Association	3.3 c)	We welcome the examination of both these topics (Vitamin D & Alcohol)	Thank you.
British Dietetic Association	3.3 e)	We welcome the examination of the effectiveness of screening for gestational diabetes.	Thank you.
British Dietetic Association	General	The current Antenatal Care Guideline is out of date in respect of FSA guidance on food safety eg oily fish, fish containing high mercury levels. The new guideline will need updating in this respect.	Thank you for this comment which we note. The current antenatal care guideline does not make a recommendation on dietary information and education and we will not be reviewing the evidence in the update.
British Dietetic Association	General	The new guideline should refer to the Department of Health's initiative 'Healthy Start'. Women will need to be advised of this at the first booking visit (can claim from 10 weeks if eligible).	Thank you. This will be considered as part of our review of information for women in the antenatal period.
British Dietetic Association	General	The dietary advice stated for treatment of constipation (Section 1.4.3 in the 2003 Guideline) needs to be re-examined. Bran or wheat fibre supplementation will not work if an inadequate fluid intake. See Prodigy Guide on Constipation in Pregnancy for more balanced advice (www.prodigy.nhs.uk/constipation).	Unfortunately we are unable to address this issue in the new update due to the limited time available.
British National Formulary (BNF)		This organisation was approached but did not respond.	
CEMACH		This organisation was approached but did not respond.	
Commission for Social Care Inspection		This organisation was approached but did not respond.	
Community Practitioners and Health Visitors Association / Amicus	General	Thank you for giving the CPHVA the opportunity to comment on this draft scope. We were not a stakeholder in the production of the last guideline but had some concerns when it was published which we would like raised in the update.	
Community Practitioners and Health Visitors Association / Amicus	3.b. bullet points 2,4 & 5, 3.3.b (see below)	The opportunity for health care professionals is identified but within the current guideline and the remit of the scope no mention is given to the crucial opportunity or contribution of health visiting in antenatal care. The antenatal period forms the basis for future family life. At least 50% of health visitors perform a holistic assessment of the mother	Thank you. We will ensure that we cross reference to the postnatal care guideline (published in July 2006) and the antenatal and postnatal mental health guideline (anticipated publication January 2007) where relevant. The assessment tool will include assessment of need based on social and mental health grounds.

Stakeholder organisation	Section	Comments	Response
		and her family's potential needs postnatally when they visit at 36 weeks. This is an opportunity to assess vulnerabilities eg unrealistic expectations, lack of support, vulnerability to mental illness, domestic violence etc as well as passing on important information such as the book 'Birth to 5' and the personal child record. These documents should be explained at this contact. The recommendation is that these books are passed on antenatally when there is time for the health visitor to discuss there use. This dovetails with the 'Normal postnatal care guideline' which advises they should be given to the mother asap after birth if she has not received them antenatally. Postnatally however is much less appropriate as there is less opportunity to discuss their contents. This contact is a core standard of the NSF for Children in England. There is also no mention of the crucial importance of assessing emotional health needs antenatally.	Please refer to the NICE antenatal and postnatal mental health guideline (anticipated publication Jan 2007).
Community Practitioners and Health Visitors Association / Amicus	3.3	The role of the health visitor to inform the women of the level of support available in the pregnancy and post natal period. This is crucial particularly if problems are anticipated or arise.	Information-giving during pregnancy will be covered by the guideline. It is not within our remit to determine who should give the information.
Community Practitioners and Health Visitors Association / Amicus	Appendix: The needs assessmen t tool.	An important component of the care pathway and should when developed be a continuous process with multi disciplinary contribution. To fail would compound the medicalisation of the normal pregnancy with the overt risk of not assessing the woman holistically. It is well documented that the social, psychological and spiritual wellbeing of the mother has an impact on the wellbeing of the baby. The health visitor contribution to the assessment is vital and it is a key part of the health visiting role so we have much experience to offer. There is an important literature on needs assessment in health visiting which makes clear how counterproductive the use of check lists and questionnaires are so real caution should go into developing a new tool which we would recommend should be a framework	Thank you.

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		(as with the assessment of the child in need) rather than a questionnaire. We suggest you access literature by Appleton and also Cowley and probably invite one of these researchers as an expert witness for this part of development of the guideline. Inter disciplinary communication of information covering the whole woman is crucial to maximise the best outcome for her self, her baby and her family.	Thank you. We will review the relevant literature.
Community Practitioners and Health Visitors Association / Amicus	Additional material	We are also attaching the content of a statement published by the CPHVA in the Community Practitioner in 2004 (Vol 77, 2 p.46) expressing our concerns on some of the content of the guideline in relation to its psychiatric components. We strongly recommend that these areas of the guideline are also revisited in the scope due to the potential impact of poor emotional health in the mother antenatally on the family and particularly the baby postnatally. There is a growing research base in this area. There is a growing suggestion from the literature that focused classes on becoming a parent and the psychosocial needs of babies should be implemented antenatally to support attachment and deal with unrealistic expectations of the infant in the postnatal period, in particular literature from Stewart-Brown and Barlow . (e.g. see Stewart-Brown, Faculty of Public Health Briefing Statement, Parenting and Public Health ISBN 1-9000273-16-0) At the moment the guideline scope is very clinical and any weakness is in its lack of attention to the psychosocial needs of couples and their children. We would recommend that the guideline considers what can be offered antenatally to support sound emotional family health in the postnatal period.	Thank you. This area is currently being addressed by the NICE guideline on antenatal and postnatal mental health (anticipated publication Jan 2007).
Connecting for Health		This organisation was approached but did not respond.	

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Croydon Primary Care Trust		This organisation was approached but did not respond.	
Department of Health	General	The Department of Health is pleased with the overall proposals which will back up our NSF and the care pathways. Our comments are mainly about the tone in which the guidance is written. We feel the tone used is very directive and prescriptive and a tone which does not reflect our philosophy of putting the women at the heart of the service.	Thank you. We will address this.
Department of Health	Title	Would you please consider keeping the title the same as the existing guideline ie routine care for health pregnant women and delete the word normal, as we feel that normal is pejorative and causes offence to many pregnant women who have problems but whose pregnancy is at least normal.	Thank you we have amended the title.
Department of Health	3a	For reasons why the guidance should be updated, it would be very much appreciated if you could consider adding the maternity strand of the NSF. The NSF asks for a routine tool to help women and health care providers work out which pathways of care are more suited for each woman's particular circumstances and to help identify those for whom Team based multidisciplinary care should be recommended. Would you consider replacing ' shared care' with 'Work Team Based' as this would reflect the new language used by the DH.	Thank you for your comments. The assessment tool will help healthcare professionals identify those women who need additional care, although it will not state who should deliver the care.
Department of Health	3b	Antenatal period also offers a range of choices around where and whom should provide antenatal care and the pathways as well as choice for childbirth which can be altered up to and including early labour.	Thank you, We will look at giving information to help women make decisions about their care including how to deliver information and when. We will not be looking at who should provide it.
Department of Health	3b	Screening is not just a choice but an option could you consider amending so it reads "options and choices for screening tests"	Amended.
Department of Health	3b	Maternity workers in the antenatal period also have an ideal opportunity to signpost other multi-agency services that could support individual women with specific problems as well as access to parent craft	We will advise about information giving to women but within the recommendations we are unable to advise about other agencies because this is beyond

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		classes and the multi-agency links and health promotion side too that we need to highlight to get HCWs engaged in understanding this wider role.	our remit.
Department of Health	3.3 a	This point says “how to identify women who require additional or shared care” which is directive and has no element of choice we feel it would be better if the text could be amended to read “how to identify those women for whom additional or team based care is recommended”	Amended.
Department of Health	3.3b	Would you give consideration to using the wording “women’s choices during pregnancy” as we feel that it would be better to use the words “women’s decision”.	Amended.
Department of Health	3.4.1	The section on how the guidance relates to other NICE guidelines misses out on your upcoming intrapartum guidance, which is due out in a few months in final form.	Amended.
Department of Health	Annex	We consider the second line should be women for whom team based or additional care should be recommended and not” women who need additional care” and identify these women seem a little too harsh., we feel that softer words are needed here. We do not think we can really say “correct pathway to be offered”. no such thing as correct just better or worse, we feel the text should be amended so it reads “to enable women to be given advice about which pathways and types of care would suit them and the women’s needs and wishes best” Would you please clarify that statement on the needs assessment tool, we consider it more appropriate of it as a risk and needs assessment tool otherwise the guidance will miss the point as she can articulate her needs already! Could the guidance refer to the the risk assessment tool be throughout pregnancy and not just as the start as things can change	Amended. The tool will be known as an assessment tool and is intended for use both at the beginning of pregnancy to plan appropriate care, and as a resource to use throughout pregnancy to identify any change.
Down's Syndrome Association		This organisation was approached but did not respond.	

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Dudley Group of Hospitals NHS Trust	2, c	Reword 'patient' to woman in 2 entries	"Patient" is relevant in this context, but we agree the word "woman" is usually appropriate in antenatal care.
Dudley Group of Hospitals NHS Trust	3	We presume the impact of this evidence relates to the normal healthy woman	Yes.
Dudley Group of Hospitals NHS Trust	3.3, c	Why specifically only vitamin D What about other substances?	Vitamin D deficiency has recently re-emerged as a public health concern.
Dudley Group of Hospitals NHS Trust	3.3, d	Will private ultra-sound screening services be considered? Will National Screening Committee research/recommendations not be used for this? Agree that national consistency is required	It is outside the remit of a clinical guideline to consider private service provision. Thank you.
Dudley Group of Hospitals NHS Trust	3.3, e	Point 2 – would like qualification on this	We will be reviewing the evidence regarding the clinical effectiveness of screening for pre-eclampsia and pre-term labour as well as developing economic models to examine the cost effectiveness of this screening.
Dudley Group of Hospitals NHS Trust	General	Will universal screening for Clamydia or Group B strep be considered?	We now have included Chlamydia screening. GBS – The National Screening Committee is already commissioning work in this area and there is unlikely to be new UK data to inform current practice before this guideline is completed.
Dudley Group of Hospitals NHS Trust	Appendix	Excellent to have a national tool/notes for documentation of set risk assessment and the option to continually record risk assessment	Thank you.
English National Forum of Local Supervising Authority Midwifery Officers	General	It is good to see that this update has been brought forward due the emergence of new evidence around antenatal care.	Thank you.
English National Forum of Local Supervising Authority Midwifery Officers	3.2 a)	Shared care may be the norm in some areas for normal healthy women but it does not indicate that there is a problem with the pregnancy. We suggest that shared care is removed from this section as identifying women who require additional care should be the focus.	Thank you. Amended.
English National Forum of Local Supervising Authority Midwifery Officers	Appendix	As in previous comments we suggest that shared care should be removed from this section.	Amended.
Evidence Based Midwifery Network	Section 2, backgroun	Northern Ireland (NI) has now officially signed up to NICE and it would be appropriate for scope to	Thank you for this comment. The current situation is as advised in the scope.

Stakeholder organisation	Section	Comments	Response
	d	include NI.	
Evidence Based Midwifery Network	3.1	Where does one consider antenatal care for the large number of women who have a disability either physical or learning where do women who have IVF fit into the programme where does the care for women who are habitual aborters or have a history of pre-term birth fit into the guideline	Women with disabilities are included unless the pregnancy is high risk (for example obstetric complications). Women with an IVF pregnancy do fall within the scope of this guideline. Women with history of recurrent first trimester miscarriage with no underlying medical cause do fall within this guideline. Women with a history of recurrent second trimester miscarriage, or those with medical complications as an underling cause for misacarriage, fall outside the scope of this guideline. Women with a history of pre-term birth fall outside the scope of this guideline.
Evidence Based Midwifery Network	3.1c	Lifestyle...could scope include provision of guidance on exercise and diet	This guidance is present in the original antenatal care guideline but will not be updated at this time.
Evidence Based Midwifery Network	3.3	Could section D include screening for mental health and domestic violence	This will be included in the needs assessment tool.
Evidence Based Midwifery Network	general	Antenatal EDUCATION does not appear to be in the scope at all and I feel really strongly about this a s a specific area for guidance...we need to get a national standardised package ...	Antenatal education is covered in the original guideline but will not be updated at this time.
Evidence Based Midwifery Network	general	Process issues: e.g. managing process of screening (reporting, filing, whose responsibility, etc)	This is outside the NICE guidance scope.
Evidence Based Midwifery Network	general	Midwife as the 1st contact-good evidence to show prevention of visit duplication therefore potentially more cost effective	Thank you for this comment, however service delivery is outside of the scope of this clinical guideline.
Evidence Based Midwifery Network	general	There is some qualitative info now available in regard to women's views on the type of health care provider	Service delivery is outside the NICE guidance scope.
Evidence Based Midwifery Network	Information	Issues such as format and method of communication of information should be addressed. Evidence is available that about 30% of women access on line info-too much scattered information	Thank you. We will consider this aspect of information-giving in the antenatal period.

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		delivered to women/evidence that over 50% of women did not report any change in behaviour or in attitude-needs standardisation	
Evidence Based Midwifery Network	general	Accurate and very careful terminology should be used when screening tools are recommended- for health professionals not to loose sight of individuality of care-risk of labelling women/categorising them early in pregnancy and depriving them from a normal, enjoyable experience.	Thank you, we agree.
Foundation for the Study of Infant Deaths		This organisation was approached but did not respond.	
Gloucestershire Hospitals NHS Foundation Trust	3.4.1.	Any antenatal and post natal guidance on the care pathway for maternal mental health must be practical & any screening initiatives must be implemented once appropriate referral pathways and services are in place to deal with this additional work load (mental health teams already have difficulty meeting referral requests often because this area of work is not specifically commissioned from mental health providers).	Thank you. Service provision and organisation of care is outside the NICE clinical guidance remit.
Gloucestershire Hospitals NHS Foundation Trust	Appendix Needs assessmen t tool	Do we have a pathway of care for those women identified as higher risk following use of the needs assessment tool? Do we need nice guidelines on e.g. management of the woman with previous preterm delivery etc?	These topics will be considered for future NICE guidance.
Gloucestershire Hospitals NHS Foundation Trust	3.b Risk Factors	It would be helpful if guidance could be provided to midwives regarding the frequency and severity of a risk that should be explained to a mother. Midwives are frequently criticised for explaining risks of low incidence (e.g. Scar rupture to woman undergoing TOS at home) despite the fact that the consequences can be catastrophic. The Trust currently is dealing with a complaint about bullying /shroud waving a in this situation.	Thank you. We will consider this when looking at what information women should be provided during pregnancy.
Gloucestershire Hospitals NHS Foundation Trust	General	The title of this document should be antenatal care for all women as the assessment is of all women at their first visit. Any defined then as low risk healthy normal women is made after that assessment.	Thank you. We will clarify this point in the introduction.
Gloucestershire Hospitals	1.1.2	It is appreciated that women require good evidence	Thank you. This will be taken into consideration.

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NHS Foundation Trust		based information to make informed choices. However, many women complain that they are so bombarded with information that they are overwhelmed and therefore don't read any of it. Can the group address what they really need to know and when? Does it all need to be given at once and do they currently really need all that they are given?	
Group B Strep Support	General	At present, there appears to be no place for re-evaluating the issue of routinely screening women for GBS carriage late in pregnancy on the NHS. GBSS believes this should be re-evaluated, particularly in the light of emerging evidence, specially Ruth Gilbert's modelling study (see http://www.ncchta.org/ProjectData/1_project_record_notpublished.asp?PjtId=1473) .	GBS – The National Screening Committee is already commissioning work in this area and there is unlikely to be new UK data to inform current practice before this guideline is completed.
Group B Strep Support	General	The current Antenatal Care guideline includes little guidance to health professionals on GBS. The ANC guideline predated the publication in November 2003 of the Royal College of Obstetricians & Gynaecologists' Green Top Guideline No 36 entitled Prevention of Early Onset Group B Streptococcal Disease. The ANC guideline should therefore be updated to incorporate the recommendations, although some of these may need to be revised in the light of evidence which has emerged since that time – the RCOG guidelines are due for review in November 2006.	GBS – The National Screening Committee is already commissioning work in this area and there is unlikely to be new UK data to inform current practice before this guideline is completed.
Healthcare Commission		This organisation was approached but did not respond.	
Liverpool Women's NHS Foundation Trust	General	There should be strong underpinning of the guidelines by the NSF and Choosing Health. The emphasis should not just concentrate on clinical issues, but recognise the importance of the wider determinants of health	Thank you. We will address this in the updated introduction to the guideline.
Liverpool Women's NHS Foundation Trust	General	There should be emphasis on pregnancy as a health window of opportunity with the potential to influence unhealthy lifestyles for the woman and her family.	Thank you. We will address this in the updated introduction to the guideline.

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Liverpool Women's NHS Foundation Trust	General	Consider the findings of the last 2 triennial reports, Why Mothers die, particularly around social exclusion and cultural issues	Thank you. We will address this in the updated introduction to the guideline.
Liverpool Women's NHS Foundation Trust	General	Ensure the guidelines incorporate the Standards for Better Health to help ensure that clinicians can meet the targets of the developmental standards whilst implementing the recommendations of the new guidelines	Thank you. We will cross refer to this document.
Liverpool Women's NHS Foundation Trust	3.3 (e)	Incorporate the findings of the CEMACH Diabetic survey, particularly around the unexpected prevalence of type 2 diabetes which will impinge on the rationale for screening for gestational diabetes	Please refer to the NICE clinical guideline 'Diabetes in pregnancy' (anticipated publication November 2007).
Liverpool Women's NHS Foundation Trust	3.3 (b) & 3.4.1	There should cross reference to NICE Intrapartum guideline to ensure evidenced based information is given to women regarding place of birth, care in labour, monitoring in labour and analgesia. Include what and when to give information	Thank you. We aim to do this.
Liverpool Women's NHS Foundation Trust	3.3 (e)	Screening for significant mental health issues- sensitivity and specificity of screening methods. Problems with availability of psychiatry services. Are interventions effective- what level of evidence?	Please refer to the antenatal and postnatal mental health guideline (anticipated publication Jan 2007).
Liverpool Women's NHS Foundation Trust	3.3 (d)	There is no reference in existing guideline to malpresentations other than breech. Would be helpful to consider these and unstable lie.	We recognise this is an important area but women with obstetric complications lie outside the scope of this guideline.
Luton and Dunstable Hospital NHS Trust		This organisation was approached but did not respond.	
Medicines and Healthcare Products Regulatory Agency (MHRA)		This organisation was approached but did not respond.	
Mid and West Regional MSLC		This organisation was approached but did not respond.	
MRC Centre of Epidemiology for Child Health	3.1.2	The guideline should cover the normal care components of the care of women with complex problems. 3.4.1 Should link with postnatal care guidelines - relates to 3.3 b)	The updated guideline will continue to provide a framework for usual care components of antenatal care. Thank you, we will cross-reference as appropriate.
MRC Centre of Epidemiology for Child	3.3 b)	This is extremely important so that advice about aspets of neontala care and screening can be	Thank you.

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Health		given.	
MRC Centre of Epidemiology for Child Health	3.4.1	Should link with postnatal care guidelines - relates to 3.3 b)	Thank you, we will cross-reference as appropriate.
MRC Centre of Epidemiology for Child Health	general	Women with problem pregnancies also need all the elements of normal antenatal care, alongside whatever other needs they have. So the normal care package has to integrate into individualised situations (eg thinking of women with diagnosed HIV infection).	Thank you. The updated guideline will continue to provide a framework for routine aspects of antenatal care.
National Childbirth Trust		This organisation was approached but did not respond.	
National Patient Safety Agency		This organisation was approached but did not respond.	
National Public Health Service - Wales		This organisation was approached but did not respond.	
NHS Health and Social Care Information Centre		This organisation was approached but did not respond.	
NHS Quality Improvement Scotland		This organisation was approached but did not respond.	
North Tees and Hartlepool NHS Trust		This organisation was approached but did not respond.	
Northwest London Hospitals NHS Trust		This organisation was approached but did not respond.	
Obstetric Anaesthetists Association	3 b)	Risk issues need to include factors relevant to anaesthesia, even if the need for anaesthesia would seem remote at the time of the risk assessment, (eg obesity, needle phobia, suxamethonium sensitivity)	Thank you. These questions will be considered for the assessment tool.
Obstetric Anaesthetists Association	3.3 b)	Not just what information should be given, but ***when*** during the antenatal period	Thank you, we will incorporate this.
Obstetric Anaesthetists Association	3.3 b)	The information offered needs to satisfy the requirements of informed consent – particularly in the emergency situation, (when there may be almost no opportunity to offer relevant information to woman / partner)	Thank you, we will take this into consideration.
Obstetric Anaesthetists Association	3.3 c)	Life style; Others issues affecting healthy women include caffeine intake, vitamin supplementation generally, the use of complimentary medical	Thank you. This update is focussing on lifestyle issues where new evidence has become available. The current antenatal care guideline contains

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		products, (increasingly common),	recommendations regarding caffeine intake, vitamin A and folic acid supplementation and complementary medicine – these recommendations still apply.
Obstetric Anaesthetists Association	3.3 d)	What is the role for screening for thrombophilias?	Thank you for your comment. It is not possible to consider this issue within the time available for the current update.
Obstetric Anaesthetists Association	Appendix: risk assessment tool	Women's risk status can change at any point during antenatal period. This tool must be usable through-out pregnancy, (one version for initial booking visit, another for subsequent visits?)	Yes, we will consider this when developing the assessment tool.
Obstetric Anaesthetists Association	General	If a tool for identifying women requiring additional care, why is a ga with the one for healthy women?	General anaesthesia is outside our scope.
PERIGON (formerly The NHS Modernisation Agency)		This organisation was approached but did not respond.	
Positively Women		This organisation was approached but did not respond.	
Princess Alexandra Hospital Harlow Essex	1. 3.3	Screening for Group B Strep	GBS – The National Screening Committee is already commissioning work in this area and there is unlikely to be new UK data to inform current practice before this guideline is completed.
Princess Alexandra Hospital Harlow Essex	2.	Guidelines on Caffine consumption	Please refer to original antenatal care guideline.
Princess Alexandra Hospital Harlow Essex	3.	Chlamydia screening	We have now included Chlamydia screening.
Princess Alexandra Hospital Harlow Essex	4.	Who is to be the first contact Midwife or GP?	Whilst we recognise the importance of this question for some professional groups, issues of staff and service organisation are outside the scope of this clinical guideline.
Princess Alexandra Hospital Harlow Essex	5. 2. NSF	Please clearly define "Health care professional"	Thank you, we will consider in the light of evidence we are going to review.
Princess Alexandra Hospital Harlow Essex	6. 3.3	Role of Doppler in Fetal Growth	Thank you, we intend to include this.
Princess Alexandra Hospital Harlow Essex	7. 3.1	Use of Risk assessment tool to cover health and social risks	Thank you. We aim to include social risks.
Princess Alexandra Hospital Harlow Essex	8. 3.4	Past psychiatric History	Thank you, this will be considered as part of mental health assessment.
Princess Alexandra Hospital Harlow Essex	9. 3.3	Use of USS in estimating Cervical length?	This will be reviewed as screening for pre-term labour.

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Princess Alexandra Hospital Harlow Essex	10. 3.1	Risk Assessment not just done at booking but at each subsequent meeting and plans made accordingly	We will consider this when developing the assessment tool.
Princess Alexandra Hospital Harlow Essex	11. 3.3	Role of Nutrition in pregnancy	The current antenatal care guideline contains recommendations regarding nutrition during pregnancy – these recommendations will still stand.
Princess Alexandra Hospital Harlow Essex	12. 3.3	Use of recreational drugs in pregnancy	The current antenatal care guideline contains recommendations regarding cannabis use during pregnancy – these recommendations will still stand.
Princess Alexandra Hospital Harlow Essex	13. 3.4.1	Standardise the screening for Gestational diabetes in pregnancy for the low risk woman.	We will be addressing this issue.
Princess Alexandra Hospital Harlow Essex	14. 3.4	Screening the low risk woman for Domestic Violence issues	We will consider this topic for the needs assessment tool.
Princess Alexandra Hospital Harlow Essex	General	I would like to point out that I would also like guidance on what you perceive to be "normal" Do you mean "Obstetrically" "Socially" "Mentally" "Physically" .....!	Thank you. Due to the difficulties inherent in this term, it will not be used in the guideline.
Regional Public Health Group - London		This organisation was approached but did not respond.	
Royal College of General Practitioners	Section 3.1	The key to the scope is now to define normal. What conditions or factors qualify a woman for non-normal care! Presumably serious pre-existing medical conditions, not just pregnancy related one, would exclude a woman from normal care e.g. existing valvular heart disease (but not asymptomatic mitral incompetence which is so common). What about women with pre-existing "medical" problems that are usually managed in primary care e.g. mild asthma, chronic stable depression, etc. Are these to be included or excluded? This is a very important point for the scope because as it reads such women would be excluded from the choice of normal antenatal care. What urgency? When do they not need immediate referral? (if at all) OR perhaps direct access ultrasound instead?	The assessment tool should clarify this issue. We will not be using the term “normal” in the guideline update. However, what is meant by the term is as you describe ie. women with no serious medical or obstetric complications. Thus women with mild asthma would be included within the scope of the guideline. Women with mental illness and taking medication would not be included. It should be noted that the guideline represents the basics of care for all women, those with complications will require additional care rather than different care. Please refer to the existing antenatal care guideline

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			for clarification of the included population. Urgency of referral/direct access ultrasound are clinical judgement/service delivery issues and as such fall outside the scope of NICE guidance.
Royal College of General Practitioners	Section 3.3	Again the key is what constitutes a "risk factor" and secondly if one is identified to which type of consultant the woman should be referred e.g. direct referral to a cardiologist for an asymptomatic woman with a heart murmur would be more appropriate than consultant obstetric referral in the first instance. There are number of common issues which may limit women's choices in antenatal care in terms of setting, carer or pathway. These include: 1 Women who are thought to be at high risk who then become low risk e.g. h/o premature labour who reach term in current pregnancy: the scope needs to consider and advise that such women should return to low risk pathways - at present they usually do not and so their choices are limited. 2 Women at increased risk for whom there is no effective intervention apart from delivery e.g. 2 previous C Sections for recurrent cause who will need a further CS. Such women can be cared for outside of secondary care and avoid a number of hospital visits and discontinuity of care by having community based care until the date of section as per local protocol 3 Women whose baby may be at increased genetic risk due to e.g. FH do not need in the first instance a consultant obstetric opinion but often a genetic	The assessment tool should clarify this issue. Thank you, we will do this. Whilst the assessment tool will help healthcare professionals decide which women will need additional care it is not within the scope of the guidance to recommend who should provide the care or where. Thank you, the algorithm will make it clear that women can be referred to an obstetrician or other specialist advice/care but can return to the care

Stakeholder organisation	Section	Comments	Response
		opinion to determine if they are really high risk. Pathways should reflect this so that they can avoid unnecessary secondary care visits. 4 Abdominal pain in pregnancy: if all such patients were referred to secondary care hospitals would be overwhelmed! When should they be referred? or when investigated in community/PC first? 5 How to manage persistent morning sickness in a normal healthy pregnant woman. 6 PIH and PET can be difficult to distinguish but have different outcomes. How can those in PC/community care distinguish and how should the PRECOG guidelines be applied in practice? 7 Small vaginal bleeds/APHs. Should all be referred in? With With what urgency? When do they not need immediate referral? (if at all) OR perhaps direct access ultrasound instead?	pathway for uncomplicated pregnancy if that is appropriate. Due to time constraints we are unable to address this issue in the current update. Guidance on this issue can be found in the current antenatal care guideline. This advice will remain unchanged in the updated version. Due to time constraints we are unable to address this issue in the current update. Due to time constraints we are unable to address this issue in the current update.
Royal College of General Practitioners		8 Use of EPCs to diagnose viability and early bleeds. When to refer? 9 Direct access to investigation, not via a consultant appt. e.g. MW examines a woman near term and thinks she may have a breech. Direct access can confirm it and then onward referral to consultant appt whereas direct access could refute the breech diagnosis and avoid an unnecessary consultant appt. All the above areas are important to women's choices, their carers, safety and secondary care workload. I would suggest that the scope should include them therefore to maximise, within a safe framework, those women who can be cared for in PC/community care; such maximisation could reduce pressure on secondary care and enable consultant teams to concentrate their skilled efforts	This is the purpose of the needs assessment tool Service organisation is outside the scope of NICE clinical guidance.

Stakeholder organisation	Section	Comments	Response
		on those high risk women for whom only they can provide appropriate care	
Royal College of Midwives		This organisation was approached but did not respond.	
Royal College of Nursing	General	The Scope states that it is only considering the care of healthy women in a normal pregnancy but that they will try to produce a needs assessment tool to identify vulnerable women, who would then be considered at high risk. However it appears that there is no intention to suggest a plan of care for these vulnerable women - we consider that this would be problematic.	Thank you. The care of women requiring additional antenatal care is outside the scope of this guideline update because there will be insufficient time available to cover these issues in a meaningful way. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward to the topic selection process.
Royal College of Nursing	Section 3.3	The Antenatal period is an essential part of preparing and supporting women on a 'Normal Birth Pathway and if it there is an attempt to reduce unnecessary interventions and promote normal birth, we would suggest a review of the following point: • What care, information, education and support do women need to have a normal birth outcome and avoid unnecessary medical interventions	The current guideline aims to update areas of antenatal care where new evidence has come to light, and as such is unable to address such wide-scoping issues. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Royal College of Nursing	Section 3.3	We also suggest the inclusion of the following points: • Preparation for parenthood is an essential point to be included to support couples in developing their parenting skills. • Education and preparation for successful breast feeding. This is an important public health aspect.	We recognise these as important issues, however we are unable to address them in sufficient depth within the time available for this update.
Royal College of Nursing	Section 3.3 e)	Section e) Screening for clinical conditions A review of the cost effectiveness of screening for Group B Streptococcus and Chlamydia Trachomatis during pregnancy Rationale	We now have included Chlamydia screening upon stakeholders' consultation. We will consider these issues in the light of evidence that we are going to review. GBS – The National Screening Committee is already commissioning work in this area and there

Stakeholder organisation	Section	Comments	Response
		There is a rising prevalence of both these infections in the population and both carry a considerable level of fetal morbidity / mortality. Treating these infections post delivery is expensive and delays discharge. Most Western Countries screen at least once in pregnancy for these infections and others screen twice.	is unlikely to be new UK data to inform current practice before this guideline is completed.
Royal College of Nursing	Section 3.3 e)	Section e) Screening for clinical conditions Screening for domestic violence and previous sexual abuse should also be included.	Thank you. These issues will be covered by the assessment tool.
Royal College of Obstetricians & Gynaecologists	3.3b and 3.4.1	Should cross reference to NICE Intrapartum guideline with respect to information that needs to be given in the antenatal period regarding place of birth, care in labour, monitoring in labour and analgesia. Include what and when to give information	Thank you. We will make this cross-reference.
Royal College of Obstetricians & Gynaecologists	3.3c	Is there a role for reviewing vitamins in general? Self-administration of vitamins is common and this might cause more harm than good. Likewise for fish oils that some women self-administer.	We are unable to address these issues within the time available for this update.
Royal College of Obstetricians & Gynaecologists	3.3c	Include role of preconception Folic acid supplementation	The current ANC guideline contains recommendations regarding folic acid supplementation preconceptually – these recommendations will still stand.
Royal College of Obstetricians & Gynaecologists	3.3c	Calcium supplementation in low risk women (following WHO trial showing some benefit in reducing impact of pre-eclampsia)	Calcium supplementation is included in the Maternal and Child Nutrition component of NICE's public health guidance.
Royal College of Obstetricians & Gynaecologists	3.3d	Nothing in existing guideline about malpresentations other than breech. It would be helpful to consider these and unstable lie.	Whilst recognising the importance if this issue, women with obstetric complications lie outside the scope of the present guideline update.
Royal College of Obstetricians & Gynaecologists	3.3d	What impact does early dating have on expected date of delivery? What is the optimum measurement to use?	Thank you. We will include these issues.
Royal College of Obstetricians & Gynaecologists	3.3d	What cut-off should used to inform SGA on customised growth charts? 10th centile or 5th? Are they useful in macrosomia?	This will be included in the guideline.
Royal College of	3.3d	As part of the section screening for growth	Management based on findings from screening will

Stakeholder organisation	Section	Comments	Response
Obstetricians & Gynaecologists		restriction, the review might wish to consider what is the appropriate action if the screen suggests a large fetus.	not be considered within this guideline update.
Royal College of Obstetricians & Gynaecologists	3.3d	As part of the issue of screening for fetal growth restriction, should the review consider the role of ultrasound if only to dispel its use. This could include the role of uterine artery Doppler, again if only to dispel its use.	These issues will be covered in this guideline.
Royal College of Obstetricians & Gynaecologists	3.3e	Should the scope include a review of the role of screening for vaginal GBS? This is frequently raised in the public media including high profile television programmes. A review of the literature would provide an updated public policy.	GBS – The National Screening Committee is already commissioning work in this area and this is unlikely to be new UK data to inform current practice before this guideline is completed.
Royal College of Obstetricians & Gynaecologists	3.3e	Should the scope include a review of the value of screening for asymptomatic bacteruria? There is a variation in practice which might be usefully resolved.	The current guideline aims to update areas of antenatal care where new evidence has come to light, and as such is unable to address such wide-scoping issues. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Royal College of Obstetricians & Gynaecologists	3.3e	With respect to screening for gestational diabetes, will there be a review of the identification of fasting hyperglycaemia?	This will be covered under screening for gestational diabetes.
Royal College of Obstetricians & Gynaecologists	Appendix	Identification of women with a high risk of preterm birth.	The current guideline aims to update areas of antenatal care where new evidence has come to light, and as such is unable to address such wide-scoping issues. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Royal College of Obstetricians & Gynaecologists	Appendix	Role of aspirin in high risk patients and identification of this group	Whilst recognising the importance if this issue, women with obstetric complications lie outside the scope of the present guideline update.
Royal College of Obstetricians & Gynaecologists	Appendix	Identification of high risk group for IUGR fetus.	The identification of women who may be at risk of carrying an IUGR baby will be included in the assessment tool.
Royal College of Obstetricians &	General	Visit structure – it is appropriate to review the advice on visits issued last time – is this still	Thank you. The structure of antenatal care visits will not be considered this time. Due to time

Stakeholder organisation	Section	Comments	Response
Gynaecologists		appropriate? What new evidence is there?	constraints on producing the guideline we will be focussing on topics where new evidence is known to have come to light.
Royal College of Obstetricians & Gynaecologists	General	Should the guideline consider what is appropriate pre-conception care for normal healthy women	Thank you. Pre-conceptual care is outside the scope of this guideline update because there will be insufficient time available to cover these issues in a meaningful way. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Royal College of Paediatrics and Child Health		This organisation was approached but did not respond.	
Royal College of Psychiatrists		This organisation was approached but did not respond.	
Scottish Intercollegiate Guidelines Network (SIGN)		This organisation was approached but did not respond.	
Sheffield Teaching Hospitals NHS Trust	General	Guideline title i.e. 'antenatal care for the normal healthy woman' appears on the surface to be completely reasonable but when all aspects of the scope are considered, especially with the inclusion of a needs assessment tool, the focus of the guideline appears that it could be anything but a guideline for normal healthy women.	Although much of the guideline update does focus on screening for pregnancy complications, this does form an important part of pregnancy care for healthy women (most of whom will have a negative screen). Also, the many areas of pregnancy care pertaining to healthy women covered in the original guideline still stand as the current guidance on antenatal care.
Sheffield Teaching Hospitals NHS Trust	3.3a	A definition of 'shared care' would be very helpful. The use of the term healthcare professional within the context of this guideline, especially if the term 'shared care' is not defined should be avoided as it can be misleading. Within statue only midwives and doctors can provide antenatal care and this should be reflected within the guideline. There is also a tension between defining and ensuring there is clarity throughout a woman's antenatal care who the lead professional is, either midwife, consultant obstetrician or GP. Information giving during pregnancy is a welcomed inclusion in the scope.	This is service delivery issue and outside our scope. Thank you.
Sheffield Teaching	3.3c	Under lifestyle the role of Vit D supplementation is	Nutrition during pregnancy is covered by the

Stakeholder organisation	Section	Comments	Response
Hospitals NHS Trust		welcomed but nutritional assessment as a whole would be more appropriate, especially with the current climate of healthy eating and its effect on health / morbidity and mortality. Substance misuse both drugs and alcohol would be more useful than scoping 'is there a safe level of alcohol'. Caffeine and smoking would also be useful. Generally it feels that a stronger slant on Public Health could have been scoped within this guideline.	original antenatal care guideline. These recommendations still stand as current guidance. Guidance on cannabis use is covered in the current antenatal care guideline, these recommendations still stand. Caffeine intake and smoking are both covered by the guidance given in the current antenatal care guideline. These recommendations still apply.
Sheffield Teaching Hospitals NHS Trust	Appendix	The needs assessment tool will be extremely useful, this needs to be utilised with first contact principles and reflective of the NSF for maternity services.	Thank you.
Sheffield Teaching Hospitals NHS Trust	Section 3.3a	Will women be given information about the "recommended frequency" of antenatal visits if they are low risk and suitable for midwife led care.	Yes, this information will be based upon the current NICE guidance.
Sheffield Teaching Hospitals NHS Trust	Section 3.3d	Will advice about ultrasound procedures to determine gestational age and fetal abnormalities take account of funding and staffing issues – particularly with respect to provision of first trimester biochemical and nuchal translucency screening?	We will be examining the cost-effectiveness of ultrasound scanning, however this does not address funding and staffing issues per se, which fall outside the scope of this NICE clinical guideline.
Society and College of Radiographers	General	The role of ultrasound in ante-natal care needs to be evaluated with evidence base to prevent unnecessary exposure to scanning for pregnant women. Inappropriate scanning requests which have no impact on patient /pregnancy management not only result in extra workload for ultrasound departments but also sometimes prove to raise unnecessary anxiety for these women. For example • Is there any value in performing reassurance scans for asymptomatic women with previous miscarriage?	We agree. We will include the issues of reassurance scans, one off scans for fetal growth checks and Doppler ultrasound in the presence of reduced liquor in the light of evidence that we are going to review.

Stakeholder organisation	Section	Comments	Response
		• For third trimester scans, what is the role of one off "fetal growth" check scan for women i;e reduced symphysis fundal height or weight loss in low risk women. • Is there any benefit for Doppler studies in presence of normal fetal growth and reduced liquor, as these are frequent requests.	
Society and College of Radiographers	General	There are also some training issues regarding the health practitioners who give the initial information and counsel the women, as there is a huge difference in their awareness of the role of ultrasound, its benefits/limitations at different gestations and when to use it appropriately. The information that the women are given should also include the difference between abnormal scan and suspicious scan	Issues of staff training fall outside the scope of this clinical guideline. Thank you.
Society and College of Radiographers	General	As well as the timing of the anomaly scans, i;e 18-20 weeks and recommendations for equipment selection, it would be useful to have recommendations regarding the minimum time allocations for anomaly scans as these seem to vary in different units. This may be especially relevant in light of increasing risks of work related upper limb disorders in sonographers.	Thank you. Time spent conducting anomaly scans is outside the scope of this guideline update as there will be insufficient time available to cover these issues in a meaningful way. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward
Society and College of Radiographers	3.3b	If all women are offered a routine dating scan, then they should be counselled earlier regarding fetal abnormalities/Downs screening before they are referred for a dating scan, as that may detect some anomalies.	Thank you.
Society and College of Radiographers	3.3d	As a dating scan also incorporates early anomaly scan-What are the choices for women who do not want anomaly screening but there is a discrepancy regarding her dates.	Thank you. We will consider this in the light of evidence and consensus we are going to have in the guideline development.
Society and College of Radiographers	3.3d	What is the earliest gestation, one can date a pregnancy with ultrasound and give an accurate EDD. If a woman has attended for scan in an EPAU and the pregnancy is dated at 7 weeks for example, should they come back for a "dating" scan later on at 11-12 weeks? This is an area where referring	We will be addressing this issue.

Stakeholder organisation	Section	Comments	Response
		midwives are not clear about. Is there evidence to suggest that dating in late first trimester is more accurate then early first trimester.	 We will be addressing this issue.
Society and College of Radiographers	3.3d	For assessing amniotic fluid, with maximum pool depth and amniotic fluid index, is there evidence to suggest that one is a better predictor than the other for oligo/hydra amnios	Thank you. Time spent conducting anomaly scans is outside the scope of this guideline update as there will be insufficient time available to cover these issues in a meaningful way. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Society and College of Radiographers	3.3d	Is there any data to suggest which estimated fetal weight formula/chart is best to use in terms of accuracy, or shall we abandon estimating fetal weights all together.	We will consider this issue in the light of evidence we are going to review.
Society and College of Radiographers	3.3d	Are there any fetal biometry charts derived for ethnic groups and multiple pregnancies and would there be recommendations that these are used?	We will consider this issue in the light of evidence we are going to review.
Society and College of Radiographers	3.3d	Given that the Head Circumference is a better predictor for gestational age, is there any value for the routine use of Bi -Parietal Diameter measurements at any gestation?	We will consider this issue in the light of evidence we are going to review.
Society and College of Radiographers	3.3e	Recommendations for how and when ultrasound of cervical length should be used in antenatal care, should it be a screening test or a diagnostic test?	We will consider this issue in the light of evidence we are going to review.
Society and College of Radiographers	General	Guidelines indicating the care for high risk women, including the role of ultrasound, with categories such as diabetes, pre-eclampsia, multiple pregnancies would be very useful.	Thank you. The care of women with high risk pregnancies is outside the scope of the present update. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Syner-Med (PP) Ltd	3 b	Will blood tests be included in the scope under screening? Tests such as Haemoglobin and Ferritin are indicative of anaemia and Iron deficiency; both are linked to negative outcomes in both the mother and child.	Blood tests are included in the current antenatal care guideline. These recommendations still apply.
Syner-Med (PP) Ltd	3 b	Will women's concerns also cover the use of blood transfusion? Many women (including specialist groups such as Jehovah's Witnesses) would not	There will be insufficient time available to consider this issue in the current update.

Stakeholder organisation	Section	Comments	Response
		consider blood as an option for treatment and alternatives could be decided upon in advance.	
Syner-Med (PP) Ltd	3.1.1 a	As discussed in the meeting the definition for the scope population should be changed to reflect the fact that the scope includes all women that are considered to be 'normal' but tests may identify potential risk factors. It would also be beneficial is the scope were to suggest potential treatment guidelines for women whose tests reveal potential risk factors.	Thank you. The care of women with high risk pregnancies is outside the scope of the present update. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
Syner-Med (PP) Ltd	3.3 b	Clarification of the exact information the mother is to be given would be beneficial. This should cover the potential risks and benefits of all treatments.	Thank you. We intend to be specific with this advice.
Syner-Med (PP) Ltd	3.3 c	The benefits of other supplementation during pregnancy should be considered at this stage. E.g. Iron supplementation; prophylactic or other wise.	Thank you. Nutritional supplementation, including iron supplementation is covered in the current antenatal care guideline. These recommendations still apply.
Syner-Med (PP) Ltd	3.3 e	Will blood tests be included in the scope under screening? Tests such as Haemoglobin and Ferritin are indicative of anaemia and Iron deficiency; both are linked to negative outcomes in both the mother and child.	Thank you. Blood tests for anaemia are covered in the current antenatal care guideline. These recommendations still apply.
Syner-Med (PP) Ltd	3.4.1	The cross referencing to other scopes does not seem to refer to the Intrapartum or Postpartum guidelines. Although in the time scale of patient management they occur after the Antenatal stage many of the issues raised in those guidelines are of direct relevance to issues and actions which will have occurred in the Antenatal stage.	Thank you. We do intend to make these cross-references and have amended the scope accordingly.
Syner-Med (PP) Ltd	General	The Intrapartum guideline reviews the Haemoglobin levels by which a pregnancy's risk level is calculated. In the Antenatal period there is a possibility to treat anaemia and so reduce the chances of low haemoglobin being a risk factor in the Intrapartum period. It is therefore suggested that part of the Antenatal guideline specifically reviews Haemoglobin target levels. This could be extended by including a review of target Ferritin levels. By measuring Ferritin levels (especially in early pregnancy) it is possible to determine which	Thank you. Blood tests for anaemia are covered in the current antenatal care guideline. These recommendations still apply.

Stakeholder organisation	Section	Comments	Response
		women are Iron deficient. By treating Iron deficiency it is possible to reduce or halt the development of Anaemia.	
The British Psychological Society	General	While the Antenatal Care Guideline (2003) included recommendations on serious psychiatric illness and antenatal screening for postnatal depression, it neglected to address the wider spectrum of psychological and mental health needs of women during pregnancy. Policy documents already recognised the significance of emotional problems during pregnancy and highlighted the importance of early identification, intervention and timely referral on to specialist help (e.g. NSF for Mental Health, DOH, 1999; Women's Mental Health: Into the Mainstream, 2002). The importance of psychological well being in pregnancy has been further emphasised by research findings of an association between maternal antenatal stress and neonatal outcomes (Gitau et al, 2001; Huizink et al, 2003) and follow up studies which have demonstrated long term implications for the development of the child (O'Connor et al, 2003). Antenatal depression has also been associated with adverse outcomes, namely prematurity, low birth weight and less optimal neurobehavioural profiles in the newborn (Field et al, 2004). Common issues in health psychology, such as adjustment difficulties and compliance, are also pertinent in maternity care. These wider aspects of psychological care, from both a physical health and mental health perspective, should be reflected in the recommendations of this Guideline review. The general finding is that psychological therapy, and especially cognitive behavioural therapy, is as effective as drugs in treating depression and anxiety and has longer lasting effects (Appleby et	Mental health needs of women during pregnancy will be included in the assessment tool. Thank you for these references. The current guideline aims to update areas of antenatal care where new evidence has come to light, and as such is unable to address such wide-scoping issues. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward. Pregnancy care for women with mental health problems has been addressed by the NICE guideline 'Antenatal and postnatal mental health' (anticipated publication Jan 2007).

Stakeholder organisation	Section	Comments	Response
		al, 1997; Centre for Economic Performance Mental Health Policy Group, 2006). It is also shown to be cost effective. Few medicines have been established as safe for use in pregnancy and in clinical experience women's reluctance to take medication and preference for psychological approaches reflects this concern. Psychological therapies should therefore be available in a timely fashion to pregnant women.	
The British Psychological Society	General for assessment tool	To keep in mind that that it is extremely important in the antenatal period to screen women for high levels of anxiety and fear as a number of research demonstrated that high levels of fear and anxiety are the factors that may contribute to preterm labour.	Thank you, we will consider this for inclusion in the assessment tool.
The British Psychological Society	General for assessment tool	The new assessment tool must be able to screen parous women for any previous traumatic labour experiences so the appropriate support is offered antenatally.	Yes.
The British Psychological Society	2.5.6.2	Whilst it is accepted that there is at present no evidence supporting the use of interventions to prevent postnatal depression it is helpful to offer information on common symptoms experienced after the birth, so women can recognise PND. This is because PND does not always present with depression. Women may feel unwell and anxious, not necessarily tearful. Because women feel unwell, they are less able to cope. This then induces feelings of guilt and shame. This may not be picked up so it is important that sound information about PND is made available to all women at the same time as information on purer medical matters. In addition, no reference to the screening for current anxiety and depression was found. These are common during pregnancy and deserve more attention (see Report by MIND).	Thank you. Issues relating to postnatal depression have been addressed by the NICE guideline 'Antenatal and postnatal mental health' (anticipated publication Jan 2007). Thank you. We intend to include in the assessment tool assessment risk of mental health issues in pregnancy. In addition, pregnancy care for women with mental health problems has been addressed by the NICE

Stakeholder organisation	Section	Comments	Response
			guideline 'Antenatal and postnatal mental health' (anticipated publication Jan 2007).
The British Psychological Society	3.1.1 a)	Ideally normal healthy women do not go through pregnancy alone. Expectations of fathers and their involvement at all stages of the process have increased considerably. Consideration should be given as to how their role can be acknowledged and supported to optimise the value of their contribution to themselves and their partners. Clinical experience and research findings show a minority of men with significant post trauma symptoms following being present during difficult deliveries (Slade, 2006). Birth preparation should emphasise choice in relation to being present at all, and particularly in relation to withdrawing during the delivery.	Thank you. Support for fathers is outside the scope of this guideline update as there will be insufficient time available to cover these issues in a meaningful way. However, NICE welcomes suggestions for future topics from stakeholders, healthcare professionals and the public and would encourage you to put your views forward.
The British Psychological Society	3.3 a)	The needs assessment tool referred to in the related Appendix should include consideration of current mild to moderate mental illness and psychological problems. At least 15% of pregnant women experience mild to moderate mental illness, with some research indicating that rates of depression are higher in the last trimester of pregnancy than postnatally (Evans et al 2001). Others experience psychological problems more specific to the situation e.g. 6% to 10% experience severe fear of childbirth to a degree which causes great distress during pregnancy (Saisto et al, 2003). Such fear also affects birthing choices and the natural birthing process. Requiring Midwives to undertake initial screening for mental health and psychological issues necessitates ready access to appropriate guidance, support and backup services. This should be provided by a mental health professional based in the maternity setting with experience in this specialist area. As recommended by the recent report on depression and anxiety disorders, clinical	Thank you. The assessment tool will include mental health needs assessment. Thank you. Service organisation and care provision is outside the scope of this clinical guideline update.

Stakeholder organisation	Section	Comments	Response
		psychology should provide at least 50% of this support (Centre for Economic Performance Mental Health Policy Group, 2006). Identifying women who require additional care should take account of previous hidden eating disorders or repeated dietary restraint because of potential impact of mothers' nutrition on developing foetus.	 Thank you. We will consider this.
The British Psychological Society	3.3 b)	Where there is an indication of fear of childbirth in excess of common levels of anxiety, referral to clinical psychology should be offered for assessment and intervention as early as possible in pregnancy. Such fear can have a complex history reflecting a post traumatic stress disorder from early childhood or previous experience of giving birth (Saisto et al, 2003). Psychological therapy has the potential to promote adjustment and coping and may enable women to choose a normal delivery over caesarean section where the latter is requested for psychological reasons (Saisto et al, 2001; Sjogren et al, 1997). There is emerging literature about fear of labour and how this relates to decisions about care in labour re elective caesareans so there needs to be an emphasis not just on informing but also systematic consideration of the reasons underpinning preferences which may relate back to 3.3a in terms of additional care. 'Identify risk issues, including social, obstetrics and medical factors' It should also say and **psychological factors**	Thank you. The assessment tool will include mental health needs assessment. Thank you. The assessment tool will include mental health needs assessment. Thank you. Amended.
The British Psychological Society	3.3 d)	Re ultrasound – ensure psychological implications in relation to the potential for increased anxiety taken account of.	Thank you. We will include psychological outcomes relating to ultrasound scanning.
The British Psychological Society	3.4.1	It is expected that the Antenatal and postnatal mental health guideline (anticipated January 2007) will cover assessment of risk of mental health	Thank you. We intend to include assessment of mental health needs of pregnant women.

Stakeholder organisation	Section	Comments	Response
		issues. However, the draft scope for that guideline addressed such a narrow range of mental illness issues there would appear to be a serious risk that over-reliance on it will result in continuing failure to address the needs of the many women who experience mild to moderate psychological problems during pregnancy, whether related to mental health or physical health. The Antenatal Care guideline for normal healthy women should ensure comprehensive recommendations related to the psychological needs of women.	
The Chartered Society of Physiotherapy	Page 2, Section 3b, second bullet point	We recommend that **'PHYSICAL'** is also added to the list of factors. Many women report musculoskeletal problems during a routine normal pregnancy which can be quite debilitating and Physiotherapy has a key role in modifying these symptoms as part of normal routine ANC.	Thank you. Amended.
The Chartered Society of Physiotherapy	Page 3 Point 3.1.2	Will women who have these risk factors identified be subsequently excluded from following the guideline?	The care of women with complicated pregnancy is outside the scope of the antenatal care guideline, although there will still be many components of antenatal care that will be relevant depending upon the particular problem(s) identified.
The Chartered Society of Physiotherapy	Page 3, Section 3.3c 'Lifestyle'	We recommend the following bullet point be added '**Is there a safe level of exercise in the antenatal period?' Are any particular forms of exercise preferential?'**	Exercise is included in the current antenatal care guideline, and its recommendations on this issue still apply.
The Chartered Society of Physiotherapy	Page 3, Section 3.3c 'Lifestyle'	Vitamin D supplementation and dietary advice: Is there any value in expanding dietary advice in the Scope to answer some of the FAQs posed by women in the A/N period – with reference particularly to foods to be avoided? Is there any hard evidence for these? Or is this advice covered in other official publications?	Dietary advice is included in the current antenatal care guideline, and its recommendations on this issue still apply.
The Chartered Society of Physiotherapy	Page 3, Section 3.3c 'Lifestyle'	Should advice be given about POM and, particularly, OTC medication/'natural' remedies? The latter are extremely popular among many women in pregnancy. If the evidence is lacking in this area, should a statement be made to this effect?	Over the counter medicines and natural remedies are included in the current antenatal care guideline, and its recommendations on these issues still apply.
The Chartered Society of	Page 4	Include a link to the **NICE guideline for the**	Thank you – we will cross-reference as necessary.

Stakeholder organisation	Section	Comments	Response
Physiotherapy	Section 3.4.1	**management of Post Natal Care.** There should ideally be a seamless flow between ANC and PNC and issues identified within the ANC guideline should be picked up in the PNC guideline. Include a link to the **NICE guideline for the management of UI.** Whilst not necessarily a problem, transient UI is a common complain of a normal routine pregnancy.	
The Chartered Society of Physiotherapy	General	**Urinary Incontinence:** The CSP was particularly concerned at the initial publication of this guideline that reference to UI was omitted. It could have been added as 6.10 – 'a healthy woman experiencing a normal pregnancy should be advised that she may experience stress urinary incontinence during pregnancy and after the birth, and on ways of managing this common symptom. Teaching pelvic floor exercises has been shown to reduce the risk of stress urinary incontinence post-natally. We have previously provided evidence for this, and would add Reilly et al (2002) BJOG, 109, 1, 68-76; and Sampselle (1998) O&G, 91, 3, 406-412 for consideration as part of the evidence base. Since the publication of the ante-natal guidelines the CSP has been involved in the development of the post-natal guideline. While this guideline does address stress urinary incontinence, we feel that the task is made more difficult by the omission of the topic from the ante-natal guidelines. The CSP 'guidelines for the management of stress incontinence' state that stress incontinence in pregnancy is 'so common as to be considered normal'. Many women experience stress urinary incontinence ante-natally, although we recognise that it is not as prevalent as in the post-natal period. **Musculoskeletal Pain e.g. Backache.** The CSP does not feel the current extent of the scope is broad enough to encompass this issue. The CSP feels that the text for this section in the current guideline is inadequate, and does not necessarily	Thank you. We will cross-reference to the urinary incontinence guideline, which contains a recommendation relating to pelvic floor muscle training during pregnancy. The current update includes areas of antenatal care where new evidence has come to light, and as such is unable to address the issue of musculoskeletal pain at this time.

Stakeholder organisation	Section	Comments	Response
		reflect the conclusions of the included studies. Ostgaard et al (reference 213) found that **individual** assessment and tailored treatment including exercises, postural advice, back care and provision of supports can all help in the management of back ache in pregnancy. This was not mentioned in the conclusions for this section. The only treatments described as possibly beneficial to pregnant women are 'exercise in water, massage therapy, and group or individual back care classes'. Whilst we recognise the benefits of exercise in water, massage and group work, these forms of rehabilitation do not suit every woman, and may even be contraindicated in pregnancy. No cautions are given in the document. Current practice in the UK is for every pregnant woman with back or pelvic pain to have the option of receiving individual physiotherapy assessment, where it is provided. This should be made clear in these guidelines and in the public document.	Thank you. We will include this in the 'Information for Women' publication.
The Multiple Births Organisation	General	The Multiple Births Foundation supports families with twins, triplet and higher order births through raising professional awareness of their special needs. After attending the Stakeholders meeting on the 4th July, it is apparent that multiple births will be excluded from this guideline. We would like to, once again, bring to your attention the urgent need for guidance in the management of multiple pregnancies and births.	Thank you for your help. We suggest that you also refer this idea to the topic selection process. Details are available on the NICE website.
The Royal Society of Medicine		This organisation was approached but did not respond.	
TIPS Limited	Page 3 0f 6 : 3.3 (b)	I would like to introduce the subject of neonatal skincare in the antenatal period to avoid parents buying up skincare products that are irrelevant for newborn care. This has the potential to stop the early over-exposure of infants to potentially damaging chemicals which, in the long term, may	Thank you. Due to time constraints we are unable to address this topic within the current update.

Stakeholder organisation	Section	Comments	Response
		avoid the development of skin conditions including eczema. Asthma and related allergies.	
UK National Screening Committee	General / additions to the scope	The NSC understands that, as an update of the guideline it is not practical to review all issues addressed in the original version. However there are some conditions which might be addressed at a level lying between a full NICE review and making no change at all. The NSC considers that group B streptococcus (GBS) falls into this category and might be included in the scope as an 'editorial' change. **Group B Streptococcus** At the recent stakeholders meeting the issue of screening for GBS was raised. It was noted that the NSC is undertaking work to address this issue but that it was unlikely to be completed within the timeframe of the guideline's development. There is a consensus amongst standard setting bodies that screening in pregnancy to prevent early onset neonatal GBS cannot be justified on the basis of the current evidence. However, GBS's inclusion in the scope need not be seen purely in terms of 'to screen or not to screen'. There is a practical consensus amongst standard setting bodies that the RCOG's GBS greentop guideline should be implemented as current best practice and the NSC has been working these bodies to disseminate the guideline and its recommendations. In the case of GBS an 'editorial' change might be made to reflect this development. **Chlamydia infection** Screening for asymptomatic Chlamydia infection in pregnancy was also raised at the stakeholder meeting and the NSC would be grateful if this could also be included in the scope. The Committee is	Thank you for these helpful comments. GBS – As the National Screening Committee is already commissioning work in this area, and there is unlikely to be new UK data to inform current practice before this guideline is completed, GBS will not be addressed in the antenatal care guideline update. We now have included Chlamydia screening. We will consider these issues in the light of evidence that we are going to review.

Stakeholder organisation	Section	Comments	Response
		working with the National Chlamydia Screening Programme (NCSP) to specify and commission two pieces of work which will contribute to the debate about this issue. The first is an assessment of screening for Chlamydia in pregnancy against NSC criteria and the second is a review of the impact, on the NHS Antenatal and Newborn Screening Programme, of the NCSP roll out in antenatal clinics. Both pieces of work will be completed within the timeframe of the guideline's development and it would be extremely useful to both the NSC and NCSP if NICE were able to use them as the basis for updating the guideline. **3rd trimester ultrasound** Another area which might be included in this, or a future workstream, is an assessment of the value of 3rd trimester ultrasound scanning and its use as a clinical management tool for normal pregnancies.	3rd trimester ultrasound – we will consider this in the light of evidence we are going to review.
UK National Screening Committee	General / 3.3b	The NSC would be happy to contribute to the identification of appropriate information to be given during the antenatal period. However work might also be undertaken on when to provide the information. In this respect, and while recognising that this is a fairly limited update, consideration of issues relating to the pre and peri-conceptual period which can impact on pregnancy outcomes would be useful. It would therefore be helpful if the role of primary care in this area and the importance of primary care, more generally, in early pregnancy was included in the scope. If this is not possible within the current scope it might be considered for inclusion in a future workstream.	Thank you for your comments. The issue of when to provide information during pregnancy will be covered in this update. Due to time constraints we are unable to address the issue of pre-conceptual care in the current update. The role of primary care in early pregnancy, and the importance of primary care generally, is a very broad topic that falls outside the scope of NICE clinical guidelines, which focus rather on specific clinical issues.
UK National Screening Committee	Screening for	The scope states that it will address 'when' screening for fetal abnormalities should take place.	Thank you. We will work closely with the National Screening Committee to ensure the 2 publications

Stakeholder organisation	Section	Comments	Response
	abnormalities	The NSC's Fetal Anomalies Screening Programme is in the process of defining the anomalies for which screening should be undertaken. Reference to this work should be made if the guideline update will address the same issue.	complement one another.
UK National Screening Committee	Screening for haemoglobinopathies	The inclusion of the role and timing of haemoglobinopathy screening is very encouraging. However it would also be useful if the interface with primary care was also included. This interface is a critical dependency for the success of the NHS Sickle Cell and Thalassaemia Screening Programme.	We will consider this issue in the light of evidence that we are going to review.
UK Newborn Screening Programme Centre	3.3	*Clinical management* *b) What information should be given during the antenatal period to inform women's decisions about care during pregnancy, labour, birth and the postnatal period.* **When** information should be given needs to be considered. Newborn screening information should be offered verbally and supported by written information in the third trimester of pregnancy as well as postnatally 24 hours before the screening test.	Thank you – we have amended the text.
United Lincolnshire Hospitals NHS Trust		This organisation was approached but did not respond.	
University College London Hospitals NHS Trust		This organisation was approached but did not respond.	
Welsh Assembly Government		Thank you for giving the Welsh Assembly Government the opportunity to comment on the above appraisal. We are content with the technical detail of the evidence supporting the provisional recommendations and have no further comments to make at this stage.	Thank you.
Welsh Scientific Advisory Committee (WSAC)		This organisation was approached but did not respond.	
West Middlesex University Hospital NHS Trust		This organisation was approached but did not respond.	
Wirral Hospital NHS Trust		This organisation was approached but did not respond.	

Stakeholder organisation	Section	Comments	Response
Wyre Forest Primary Care Trust		This organisation was approached but did not respond.	
Yorkshire and Humber Local Supervising Authorities	3.3b.	We are sure that information about place of birth is considered as part of the information to be given during the antenatal period. This is obviously a good place to provide guidance for midwives and others to help reinforce home birth as a viable option for low risk women.	This has been covered in the NICE intrapartum care guideline.
Yorkshire and Humber Local Supervising Authorities	3.3c	We welcome the inclusion of the role of vitamin D supplementation and of safe levels of alcohol in pregnancy, as both topics are controversial	Thank you.
Yorkshire and Humber Local Supervising Authorities	3.3c	Please could consideration be made to include reference to referral to a Dietician form women with a BMI below 18 or above 35, although we acknowledge that this may, but in practice doubt, it occurs when referral to an Obstetrician is made	Thank you. We will consider this issue within the development of the antenatal assessment tool.
Yorkshire and Humber Local Supervising Authorities	3.3c	Could the new and emerging role of the Health Trainer be highlighted within the scope, for those women identified as wanting help to change their lifestyle	This is a service delivery issue, and outside the scope of NICE clinical guidance.
Yorkshire and Humber Local Supervising Authorities	3.3c	Could the scope link NICE Public Health guidance, as wee doubt that midwives consider it as relevant unless it is badged under a maternity related topic	We will refer to any other relevant NICE guidelines where appropriate.
Yorkshire and Humber Local Supervising Authorities	3.3d	We welcome the consideration of the inclusion of guidance in relation to the use of Individualised/Customised Growth Charts (CGC), as it is clinically controversial, but yet advocated within CESDI 8th report. See West Midlands Perinatal Institute http://www.gestation.net/main.htm The CGCs are used in at least 50 maternity units now in Engalnd and Wales. WMPI are demonstrating “increased antenatal detection of growth problems and reduced referrals for unnecessary investigations” http://www.perinatal.nhs.uk/pnm/Update2006.pdf Could the guidance link with recommendations about a consistent way to measure fundal height, training needs, antenatal records that support their use and when to refer for further monitoring	Thank you. The effectiveness of the use of growth charts will be included in the guideline.
Yorkshire and Humber	3.3.	Could the scope include a specified Antenatal	The structure of antenatal records documentation

Stakeholder organisation	Section	Comments	Response
Local Supervising Authorities		records document. This would be very controversial, but the robustness of the record assists in prompting aspects of care for the well-being of women and supporting midwives in practice	remains outside the scope of this guideline update because there will be insufficient time available to cover the issues involved in a meaningful way
Yorkshire and Humber Local Supervising Authorities	3.4.1	Can this scope cross-reference any current or proposed NICE Public health interventions and technology appraisals, unless they specifically exclude pregnancy e.g. PHI002 Physical activity 11th wave Mar 2006 PHI001 Smoking cessation 11th wave Mar 2006 Substance misuse interventions 11th February 2007	We will refer to any other relevant NICE guidelines where appropriate.