Intrapartum care for high risk women
Consultation on draft scope
Stakeholder comments table
13 August 2015 – 11 September 2015

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment	Stream
The Royal College of Midwives	General	General	RCM welcomes the development of this important guideline.	Thank you for your comment.	Medical and obstetric
The Royal College of Midwives	General	General	The outlined scope is comprehensive but consequently extremely large. Guidance would be more manageable if it were split between medical and obstetric complications.	Thank you for your comment. This guideline has been commissioned by NICE to be developed in two parallel work streams (intrapartum care for women with medical conditions and women with obstetric complications) but will be published as a single guideline.	Medical and obstetric
The Royal College of Midwives	General	General	The term high risk is known to be disturbing to many women. The use of this term should be reconsidered and could be replaced with the term 'complex needs'.	Thank you for your comment. Following several comments from stakeholders regarding the potentially disturbing impact on women of the term "high risk", the guideline title has been changed to "Intrapartum care for women with existing medical conditions or obstetric complications and their babies".	Medical and obstetric
The Royal College of Midwives	General	General	The guideline should cover the process for shared decision making in detail to ensure that women are advised of key facts that enable them make informed choices as outlined in the Supreme Court ruling in the case of Montgomery versus Lanarkshire Health Board. The guidance should include advice to caregivers on how to provide this information.	Thank you for your comment. It is agreed that information provision is a crucial part of women's informed decision making, and the guideline will cross-refer to recommendations on shared decision-making in the NICE guideline on patient experience in adult NHS services guideline (CG138). Separate review questions have been drafted in the scope for women with medical conditions and those with obstetric complications with the aim of addressing their information	Medical and obstetric

				needs. The precise issues to be addressed through these review questions will be clarified by the Guideline Committee.	
The Royal College of Midwives	General	General	There should be clear cross-referencing to other guidelines when this is the reason that the subject areas have been excluded from the scope. Guidance on mental health should be included here.	Thank you for your comment. The rationale for the main areas excluded from the scope has now been added. Regarding the issue of mental health during labour and birth, NICE will consider how best to address this area in future. This is a broader issue that is pertinent to all births not just those with a higher risk of adverse outcomes. The scope of this guideline is insufficiently broad to cover recommendations for each mental illness.	Medical and obstetric
The Royal College of Midwives	General	General	Women with social factors that make them high risk would significantly benefit from targeted continuity of care. Intrapartum care for these women could be included in the guideline on *Pregnancy and complex social factors.*	Thank you for your comment. Regarding the issue of intrapartum care for women with social and complex needs, NICE will consider how best to address this area in future.	Medical and obstetric
The Royal College of Midwives	General	General	It would be useful to expand antenatal guidelines covering medical conditions in pregnancy e.g. hypertension to cover the whole of the woman's journey and include intrapartum care.	Thank you for your comment. This has been passed to NICE for consideration when the relevant condition-specific maternity guidelines are updated.	Medical
NHS England	General	General	I wish to confirm that NHS England has no substantive comments to make regarding this consultation.	Thank you for your comment.	Medical and obstetric
The Royal College of Surgeons of England	General	General	The College will not be submitting a response on this particular topic.	Thank you for your comment.	Medical and obstetric
The Division of	General	General	It would be helpful if NICE could produce	Thank you for your comment. This request has	Medical and

Women's Health, King's College, London			guidelines from preconception/antenatal care to care of the newborn for specific conditions/complications to cover the whole care pathway. Maybe suggest changing the guideline title- intrapartum care for women with medical conditions/obstetric complications? I wouldn't consider a woman high risk if she had a breech pregnancy at term. Social high risk and complexity and many of those 'risk factors' (age/ obesity/ poverty/ ethnicity etc.) are very important but many women do not develop any complications. If they do they would be brought into the scope of these guidelines. It is better to have care pathway guidance for women with social complexity separately. How does any realignment of the maternity guidelines fit with the continuity of carer work that I understand is going to a Rapid Update committee? In these austere times large (expensive) guidelines have to make a difference! Its worrying that (as worded) it seems to	been forwarded to NICE for consideration in future updates of existing guidelines. Following several comments from stakeholders, the title of the guideline has been changed to "Intrapartum care for women with existing medical conditions or obstetric complications and their babies". Regarding the issue of intrapartum care for women with social and complex needs, NICE will consider how best to address this area in future. Obesity is included in the scope as a medical condition in "Key areas that will be covered". Thank you for your comment. NICE have oversight of the various related pieces of guidance and will ensure that recommendations made in this guideline do not contradict those made in the rapid update of the guideline on intrapartum care for healthy women and babies which is due to be published before this guideline. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and	obstetric

			reopen both place of birth and fetal monitoring… but maybe the best available evidence for these in the 'high risk' (such a heterogenous notion) is going to come up with an answer…. It would seem more appropriate to focus this guideline on the management of women with pre-existing medical conditions, given concerns about the numbers of women who died during 2009-2012 who had co-existing morbidity and increasing numbers of women who become pregnant with medical complications. Care during and after pregnancy should also be included, as women remain at risk of adverse outcomes during and beyond the immediate postnatal period – more women died postnatally than during pregnancy or labour in 2009-2012 (MBBRACE-UK 2014). Management of obstetric complications in labour, women who have no antenatal care and women whose babies are at high risk of adverse outcomes present a very wide range of issues and thus more appropriate to consider in a separate guideline. There is no reference in the scope to the need to consider the optimal multi-disciplinary team needed to care for women with pre-existing medical complications or how	indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline. With regard to the size of the scope and the need to adequately cover areas regarding the intrapartum care of women with medical conditions and those with obstetric complications, this guideline will be developed in two parallel work streams. Although the importance of continuity of care (antenatally, during labour and postnatally) is well recognised, this guideline is limited to intrapartum care of women considered to be at high risk for adverse outcomes or their babies who are at high risk of adverse outcomes. Antenatal care planning involving a multidisciplinary team has been added to the scope. The proposed review question will focus	

			services should be organised. Our own work shows wide variation in MDT care, in terms of membership, who is involved, when and where teams meet and lack of evidence of benefit on pregnancy, birth or postnatal outcomes.	on whether antenatal care planning involving a multidisciplinary team improves intrapartum outcomes for women with existing medical conditions.	
Royal College of Paediatrics and Child Health	General	General	Need to cover planning for delivery – information to parents, preparation e.g. visit NNU, who needs to be present at delivery	Thank you for your comment. Separate review questions have been drafted in the scope for women with medical conditions and those with obstetric complications with the aim of addressing their information needs. The precise issues to be addressed through these review questions will be clarified by the Guideline Committee.	Medical and obstetric
Royal College of Paediatrics and Child Health	General	General	No specific mention is made of placenta praevia, serious fibroid disease, or congenital malformations of the uterus. We accept that abdominal pregnancy, placenta accreta and other unusual conditions may be too rare to justify inclusion. And what about women who have been subjected to FGM, especially type 3?	Thank you for your comment. These topics were not prioritised for inclusion in the scope due to the small numbers of women affected and the existence of the NICE-accredited RCOG Green-top guideline related to female genital mutilation. The scope now includes a table outlining the main areas of exclusion and the rationale in each case.	Obstetric
British Maternal and Fetal Medicine Society	General	General	Whilst we accept the guidance can't all be in one mammoth documented – other NICE guidelines, good practice papers, green top guidelines – it would be optimal if the signposting to other resourses' is very clear e.g. with web links	Thank you for your comment. Following comments from several stakeholders and advice from NICE, we have amended the scope to improve cross-referencing and clarity. The scope now includes a table outlining the main areas of exclusion and the rationale in each case. The final guideline will include signposting to ensure ease of navigation across the various items of related guidance.	Medical and obstetric
British Maternal	General	General	In view of all the reconfigurations that are	Thank you for your comment. It has been clarified	Medical and

and Fetal Medicine Society			taking place around the UK, this is an opportunity to advise re supporting services necessary for a Consultant led unit dealing with these high risk cases, so should this be included in the scope?	that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline. However, the medical conditions and obstetric complications prioritised for inclusion in this guideline are identified in CG190 as being associated with increased risk suggesting planned birth at an obstetric unit.	obstetric
British Society for Antimicrobial Chemotherapy	General	General	Members of the British Society for Antimicrobial Chemotherapy (BSAC) have no comment to make on the draft scope consultation –Intrapartum Care for High Risk women.	Thank you for your comment.	Medical and obstetric
Royal College of Psychiatrists'	General	general	While we can understand why severe mental illness is excluded, given the recent revision of the NICE guidelines on Antenatal and Postnatal Mental Health, we would ask NICE to ensure that the future guidance on intrapartum care references and points to these APMH guidelines. We do not have any further input.	Thank you for your comment. The scope has been amended so that the excluded areas signpost to existing guidance where this exists. Regarding the issue of mental health during labour and birth, NICE will consider how best to address this area in future. The final guideline will include signposting to ensure ease of navigation across the various items of related guidance.	Medical
Department of Health	General	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.	Medical and obstetric
Academic Centre for Women's Health, University of Bristol &	General	General	Is low risk and high risk a terminology that is not very up to date, for example with regards to commissioning pathways (intermediate/ intensive)?	Thank you for your comment. Following several comments from stakeholders, the title of the guideline has been changed to "Intrapartum care for women with existing medical conditions or obstetric complications and their babies". This avoids use of the terms low and high risk.	Medical and obstetric

Southmead Hospital					
RCN	General	General	This is to inform you that the RCN has no comments to submit to inform on the above draft scope consultation at this time.	Thank you for your comment.	Medical and obstetric
Royal College of Obstetricians and Gynaecologists	General	General	The guideline scope is comprehensive and reads well Could the following be taken into account: • Whether level of seniority of staff caring for these women and their babies affect outcomes? • Is there any guidance on optimal staffing for delivery suite?	Thank you for your comment. The importance of identifying the optimal service configuration is recognised as an important aspect of care, although optimal staffing, including seniority of staff, is beyond the scope of this guideline. Antenatal care planning involving a multidisciplinary team has, however, been added to the scope. The proposed review question will focus on whether antenatal care planning involving a multidisciplinary team improves intrapartum outcomes for women with existing medical conditions.	Medical and obstetric
Association for Improvements in the Maternity Services	General	General	Whilst we quite understand, for the purposes of this guideline,	Thank you for your comment. Please see response to Comment 137.	Medical and obstetric
Association for Improvements in the Maternity Services	General	General	the exclusion of such groups, and we recognize the clinical value of Green	Thank you for your comment. Please see response to Comment 137.	Medical and obstetric
Association for Improvements in the Maternity Services	General	General	Top Guidelines, we would like to point out that the RCOG does not have the same consultation process as NICE, including consumer voices, and a number of the subjects obviously need such input (e.g. Sickle Cell Disease and Third and Fourth Degree	Thank you for your comment which was passed to NICE for consideration in their discussions with the RCOG Green-top Guidelines team. Due to the high prioritisation of topics (existing medical conditions and obstetric complications) for inclusion in the scope of this guideline, the	Medical and obstetric

			tears.) We would like this point to have general consideration.	decision was made to exclude certain areas that are covered by the NICE-accredited RCOG Green-top Guidelines.	
Association for Improvements in the Maternity Services	General	General	We think it most important to emphasise here the woman's overriding right to decide her place to give birth. We are still receiving many pleas for help from women who for sound reasons (including psychiatric outcomes, which are not at present measured for place of birth) have decided on a home birth, whatever their levels of assessed risk. Many of them have been traumatised by previous births. We are also still receiving cases where women have been judged a risk to their babies for making such a choice and have been referred to social services. This creates intense, and harmful, stress to mother and unborn child. It is being used as an unethical controlling mechanism to get women to 'comply', despite the fact that coerced consent is not valid consent, and treatment to which the women had not consented is known to be a risk factor for post-partum PTSD. For some women, the option of birthing in a Midwifery Unit, is prevented by their entry criteria, despite the fact that for some this would be a safer option. (Double spacing was unintentional here. J.R)	Thank you for your comment. It is agreed that woman may choose any birth setting and they should be supported in their choice. This is emphasised in the NICE guideline on intrapartum care for healthy women and babies (CG190). It has been clarified during revision of the scope for this guideline that CG190 has evaluated planned place of birth (and indications for transfer to obstetric care). These topics have, therefore, been removed from the scope for this guideline.	Medical and obstetric

Association for Improvements in the Maternity Services	General	General	See comments on use of word 'appropriate' above. Unfortunately referrals for a consultant opinion in our clients' reports are almost invariably used for the purpose of giving the woman a good talking to and to persuade her into having a hospital birth which she has set her heart and mind against. Could it please be emphasised that such referrals are for information and an opinion, and if this were to be given in a non-authoritarian manner which emphasises the woman's right to decide, this would encourage continued contact with services, improve future communication and care, and enable women to change their minds about place of birth And when women do end up giving birth in a place they did not want, they would be more likely to avoid trauma and depression and would be likely to feel happier postnatally and beyond.	Thank you for your comment. The concern about using the term "appropriate" is acknowledged. It has, however, been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth (and indications for transfer to obstetric care). These topics have, therefore, been removed from the scope for this guideline.	Medical and obstetric
Association for Improvements in the Maternity Services	General	General	**Omission – ambulance services**	Thank you for your comment. The settings that will be covered in the guideline have been amended to refer to the ambulance service.	Medical and obstetric
Association for Improvements in the Maternity Services	General	General	Where transfers are necessary to hospital, we have had a trickle of complaints about problems with the ambulance service – both delays and inappropriate actions. Ambulance services are stretched, and often covering larger areas than before. The quality and speed of this service is crucial for intrapartum	Thank you for your comment. The settings that will be covered in the guideline have been amended to refer to the ambulance service. It has, however, been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric	Medical and obstetric

			care for high risk women.	care. These topics have, therefore, been removed from the scope for this guideline.	
Association for Improvements in the Maternity Services	General	General	We shall wish to comment particular on VBAC and 42 week Pregnancies, but would prefer to do so at the draft guideline stage.	Thank you for your comment.	Medical and obstetric
The Royal College of Anaesthetists	General	General	This is a welcome guideline and overall will cover much of the care of high risk women; perhaps the authors should consider addressing the level of monitoring of such women and the location, for example the need for intra-arterial and CVP monitoring and whether this should be available on a HDU or a labour ward higher dependency bay.	Thank you for your comment. The proposed review questions now include consideration of the need for invasive monitoring using an arterial line and central venous pressure in women with cardiac disease. The precise issues to be addressed through this review question will be clarified by the Guideline Committee.	Medical and obstetric
The Division of Women's Health, King's College, London	2	29-33 / 52 53	Contradict one another.	Thank you for your comment. The phrase "who have complicating social factors" has been removed from the equality considerations section to remove the contradiction with the text in the other sections of the scope. Regarding the issue of intrapartum care for women with social and complex needs, NICE will consider how best to address this area in future.	Medical and obstetric
British Maternal and Fetal Medicine Society	2	29-33, 52-53	Lines 29-33 suggests this will look at those with complicating social factor, 52-53 – suggests those with high risk social circumstances will be excluded – thus that was not clear	Thank you for your comment. The phrase "who have complicating social factors" has been removed from the equality considerations section to remove the contradiction with the text in the other sections of the scope. Regarding the issue of intrapartum care for women with social and complex needs, NICE will consider how best to address this area in future.	Medical and obstetric
The Division of	2	39	The medical issues section of the guidance	Thank you for your comment. Amendments have	Medical

Women's Health, King's College, London			should apply to term and preterm. A woman with a cardiac condition who is in labour at 36+5 will have the same medical considerations PLUS the preterm birth aspect.	been made to the scope to clarify that this guideline will cover the intrapartum care of women with medical conditions who are in labour whether it is preterm or at term.	
Ferring Pharmaceuticals Ltd	2	39	It is suggested to specify that the guideline is related to spontaneous labour only and thus add the word spontaneous as in - Women who go into **spontaneous** labour who are at term (from 37+0 weeks) and at high risk..	Thank you for your comment. Amendments have been made to the scope to clarify that women who are in spontaneous or induced labour are within the scope of this guideline. Recommendations will be considered regarding management of their medical condition or obstetric complication rather than on induction procedure.	Medical and obstetric
The Royal College of Anaesthetists	2	39	We are not completely sure of the rationale for applying this only to women who are 37+ weeks.	Thank you for your comment. Amendments have been made to the scope to clarify that this guideline will cover the intrapartum care of women who are in labour whether it is preterm or at term.	Medical and obstetric
The Multiple Births Foundation	2	42	We support the separation into the two main groups as a sensible way to cover this wide ranging topic.	Thank you for your comment. This guideline has been commissioned by NICE to be developed in two parallel work streams (intrapartum care for women with medical conditions and women with obstetric complications) but will be published as a single guideline. In the revised scope key areas to be covered and the proposed review questions have also been separated according to the two work streams to aid clarity.	Medical and obstetric
Ferring Pharmaceuticals Ltd	2	44	It is suggested to specify that this guideline is related to spontaneous labour only and thus add the word spontaneous as in - women in **spontaneous** labour who are identified as high risk because of obstetric…….	Thank you for your comment. Amendments have been made to the scope to clarify that women who are in spontaneous or induced labour are within the scope of this guideline. Recommendations will be considered regarding management of their medical condition or	Medical and obstetric

				obstetric complication rather than on induction procedure.	
Royal College of Paediatrics and Child Health	2	46 and 49	There is a potential conflict here. Does the guideline intend to cover babies with conditions such as severe congenital thrombocytopenia or severe ventriculomegaly, both conditions that potentially impact on mode of delivery? The wording needs to clarify this.	Thank you for your comment. In light of this and comments from other stakeholders, amendments have been made to clarify that the scope does not cover the intrapartum care of women whose babies are identified antenatally as being at high risk of adverse outcomes exclusively because the baby has a congenital disorder.	Medical
Ferring Pharmaceuticals Ltd	2	48	It is not clear that the scope of this guideline excludes women whose labour has been induced. It ts requested that this is clarified.	Thank you for your comment. Amendments have been made to the scope to clarify that women who are in spontaneous or induced labour are within the scope of this guideline. Recommendations will be considered regarding management of their medical condition or obstetric complication rather than on induction procedure.	Medical and obstetric
Royal College of Paediatrics and Child Health	2	49	Why exclude congenital abnormalities? These deliveries and neonatal care require expert planning and management.	Thank you for your comment. Babies with known congenital abnormalities were not prioritised for inclusion in the scope although it is recognised that their care is important and complex. The priorities for inclusion are medical conditions and obstetric complications that result in high mortality or morbidity which can be reduced through high-quality intrapartum care.	Medical and obstetric
Baby Lifeline: The Mother & Baby Charity	2	51	Where will the care of women in preterm labour WITH medical conditions be addressed?	Thank you for your comment. Amendments have been made to the scope to clarify that this guideline will cover the intrapartum care of women with medical conditions who are in labour whether it is preterm or at term.	Medical
Royal College of Paediatrics and	2	52	Solely as a result of…. i.e. these women and babies may also have high clinical risks e.g.	Thank you for your comment. The text has been amended as suggested.	Medical and obstetric

Child Health			IUGR		
The Royal College of Anaesthetists	2	53	Does 'personal or social circumstances' include psychiatric disorders or are women with mental conditions covered by this guidance?	Thank you for your comment. Women with mental health conditions are not covered by the scope of this guideline. Regarding the management of mental health conditions during labour and birth, NICE will consider how best to address this area in future. This is a broader issue which is pertinent to all births not just those with a higher risk of adverse outcomes.	Medical
Baby Lifeline: The Mother & Baby Charity	3	54	Why will women with planned CS because of high risk of haemorrhage be excluded as they certainly fall within the definition of high risk given [Section 3.1, line 359]?	Thank you for your comment. The scope has been amended following stakeholder feedback and this population is now included.	Medical
The Division of Women's Health, King's College, London	3	54 / 87	Contradict another.	Thank you for your comment. The exclusion of "women in labour without known medical conditions who have a caesarean section that is planned as part of antenatal care" is not believed to contradict the included issue of "care of women during labour and/or birth who have had a previous caesarean section". The first group is those women whose caesarean section is scheduled for the current birth, whilst the second group is those women who experienced a caesarean section during a previous pregnancy.	Obstetric
Baby Lifeline: The Mother & Baby Charity	3	58	Is it not just common sense that women at greater risk of adverse outcomes, where the risk can be mitigated by intervention, should be cared for in settings where the necessary intervention can be undertaken?	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this	Medical and obstetric

			If non hospital based setting are to be considered for high risk women it is essential to consider the facilities for timely transfer and treatment should complications arise (eg there are no obstetric flying squad / factors limiting ambulance response times)	guideline. However, the medical conditions and obstetric complications prioritised for inclusion in this guideline are identified in CG190 as being associated with increased risk suggesting planned birth at an obstetric unit.	
The Royal College of Anaesthetists	3	59	High risk women should not have planned deliveries in a community setting without full understanding of the risks to themselves and baby.	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline. However, the medical conditions and obstetric complications prioritised for inclusion in this guideline are identified in CG190 as being associated with increased risk suggesting planned birth at an obstetric unit.	Medical
The Royal College of Anaesthetists	3	61-76	This list should include neurological disorders as well as diabetes, which effects such a high percentage of the population now.	Thank you for your comment. It was considered that the emphasis of care for women with epilepsy is in the preconception and antenatal periods and that guidance on intrapartum care for women with epilepsy would be best placed in the NICE guideline on epilepsies (CG137). NICE will consider how best to address this area in future. Other neurological disorders were not prioritised for inclusion because of their relative rarity. The NICE guideline on diabetes in pregnancy (NG3) has been updated recently and there is a cross-reference to this in the scope.	Medical
The Division of Women's Health, King's	3	62-64	Covered in the 2014 intrapartum guidelines "Place of birth for women at high risk of adverse outcomes in labour, including	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has	Medical and obstetric

College, London			transfer of care for women who are identified as being at low risk at the start of labour who develop a complication or obstetric emergency." This is unclear and doesn't make sense. Much of what this seems to be saying has already been covered in intrapartum care CG90. I don't think the recent Dutch studies will change the conclusions and 2014 recommendations. It's one thing to consider place of birth for women at high risk of adverse outcomes before they go into labour (which hasn't been done before). What are the risks and what should they be told? And are they (the mothers) safer in out of hospital settings? Are their babies safer, as safe, less safe in out of hospital settings? But it is quite another matter to reopen and repeat what's already been done with women at low risk who develop complications which is how this reads at present. Women cannot be at high risk of adverse outcomes in labour AND low risk at the start of labour. IPC has already dealt with the transfer of care of women from non-obstetric settings who are identified as being at low risk at the start of labour who develop a complication or obstetric emergency. Unless there is work showing that even high-risk women (and maybe their babies) do better (or equally well) out of hospitals that I am unaware of?	evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline.	

			THIS MUST BE CLARIFIED.		
Royal College of Paediatrics and Child Health	3	65	Assume this list is indicative and not exhaustive	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics and associated risk assessment have, therefore, been removed from the scope for this guideline.	Medical **and obstetric**
The Division of Women's Health, King's College, London	3	69	All asthma or those on long term steroid use?	Thank you for your comment. In response to this and comments from other stakeholders, amendments have been made to clarify that intrapartum care for women with asthma and women receiving long-term steroid medication for any condition will be covered as separate key areas.	Medical
Royal College of Obstetricians and Gynaecologists	3	69	Might be helpful to clarify the severity of asthma – mild asthma should pose no problems during labour and these women can be managed in low risk midwifery-led units.	Thank you for your comment. In response to this and comments from other stakeholders, amendments have been made to clarify that intrapartum care for women with asthma and women receiving long-term steroid medication for any condition will be covered as separate key areas. Additionally, it has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline. It is noted that CG190 suggests planned birth at an obstetric unit for women with asthma requiring an increase in treatment or hospital treatment.	Medical
The Royal	3	71	The authors ought to include <u>all</u>	Thank you for your comment. Thrombotic	Medical

College of Anaesthetists			haematological disorders - unsure why thrombotic disorders should be excluded.	disorders are covered by the RCOG Green-top guideline on thrombosis and embolism during pregnancy and the puerperium. This is noted in the table explaining exclusions in Section 2.3 of the scope.	
Baby Lifeline: The Mother & Baby Charity	3	72	Why are platelet disorders included with subarachnoid haemorrhage and a-v malformations? Are they excluding subarachnoid and a-v bleeds not associated with platelet disorders – if so why?	Thank you for your comment. An amendment has been made to separate the issues related to platelet disorders from those associated with subarachnoid haemorrhage and/or arterio-venous malformations of the brain. Women with platelet disorders are now included in the same group as women with non-thrombophilic haematological disorders. Similar amendments have been made to the proposed review questions.	Medical
London Labour Ward Leads Group	3	73	Should platelet disorders be on a separate line? SAH and AVM together, but platelet disorders are not linked to these neurological conditions	Thank you for your comment. The suggested amendment has been made.	Medical
Royal College of Obstetricians and Gynaecologists	3	73	Platelet disorders would sit better in line 71 with non-thrombophilic haematologic disorders.	Thank you for your comment. An amendment has been made to separate the issues related to platelet disorders from those associated with subarachnoid haemorrhage and/or arterio-venous malformations of the brain. Women with platelet disorders are now included in the same group as women with non-thrombophilic haematological disorders. Similar amendments have been made to the proposed review questions.	Medical
The Division of Women's Health, King's	3	74-76	Needs more details on what constitutes a renal problem	Thank you for your comment. An amendment has been made to the scope to specify that the group of women with renal problems will focus on	Medical

College, London				those with an acute kidney injury or chronic kidney disease.	
Baby Lifeline: The Mother & Baby Charity	3	81	Does this mean women with previous shoulder dystocia are low risk?	Thank you for your comment. The inclusion of women whose babies have shoulder dystocia does not imply that they would be considered low-risk during their current pregnancy. However, in response to several stakeholder comments, amendments have been made for clarity to the list of excluded populations due to complications in previous pregnancy and care of women who have babies with shoulder dystocia has been removed from the scope. This is noted in the table of exclusions in Section 2.3 of the scope.	Obstetric
The Division of Women's Health, King's College, London	3	81	The risk assessment and intrapartum care of "women who have babies with shoulder dystocia" is unclear. Do they mean 'making risk assessments for shoulder dystocia on every woman (and does this follow the failure to do so in Montgomery legal case?). OR is it the intrapartum management of women at risk (eg diabetes/ suspected macrosomia), or is it the intrapartum management of shoulder dystocia when it happens? OR do they mean the risk assessment and intrapartum care of women who have a HISTORY of baby with shoulder dystocia? Or all three? But then women with previous shoulder dystocia seem to be excluded (line 154) which I always understood was the best predictor of recurrent shoulder dystocia.	Thank you for your comment. The questions did not refer to the Montgomery legal case nor pertain to obtaining informed consent. The questions referred to "the intrapartum management of women at risk" and "the intrapartum management of shoulder dystocia when it happens" which may include "women who have had a history of a baby with shoulder dystocia". However, shoulder dystocia has now been removed from the scope in response to other stakeholder comments and this is noted in the table of exclusions in Section 2.3 of the scope.	Obstetric
Royal College of	3	81	Presumably this means women who have	Thank you for your comment. Shoulder dystocia	Obstetric

Obstetricians and Gynaecologists			previous had a pregnancy where the delivery was complicated by shoulder dystocia? The management of shoulder dystocia is addressed in an RCOG GTG (no 42)	has been removed from the scope in response to stakeholder feedback. This is noted in the table of exclusions in Section 2.3 of the scope along with a cross-reference to the RCOG Green-top Guideline.	
Royal College of Paediatrics and Child Health	3	81 and 249	"Women who have babies with shoulder dystocia". Until delivery occurs, there cannot be shoulder dystocia, so it is not a risk factor as such. What should be written here is 'Women for who estimates of fetal size place them at risk of shoulder dystocia'.	Thank you for your comment. Shoulder dystocia has been removed from the scope in response to stakeholder feedback. This is noted in the table of exclusions in Section 2.3 of the scope along with a cross-reference to the RCOG Green-top Guideline.	Obstetric
London Labour Ward Leads Group	3	81-249	Confusing the way it is written "women where the birth is complicated by shoulder dystocia" may be clearer	Thank you for your comment. Shoulder dystocia has been removed from the scope in response to stakeholder feedback. This is noted in the table of exclusions in Section 2.3 of the scope along with a cross-reference to the RCOG Green-top Guideline.	Obstetric
Royal College of Paediatrics and Child Health	3	General	Others e.g. congenital infection, illegal drug use, not all are covered by other guidelines	Thank you for your comment. Women who misuse substances are covered by the NICE guideline on pregnancy and complex social factors (CG110). Regarding the issue of intrapartum care for women with social high risk and complexity, NICE will consider how best to address this area in future. This is a broader issue which is pertinent to all births not just those of women with medical conditions or obstetric complications.	Medical and obstetric
The Multiple Births Foundation	4	123	We support the exclusion of multiple births in this Guideline on the basis that it would be far better to include all intra partum care for multiples in the next revision of the NICE Multiple Pregnancy Guideline 129. While	Thank you for your comment regarding intrapartum care for women with multiple pregnancy. NICE will consider how best to address this area in future.	Obstetric

			appreciating that NICE has a busy schedule we would welcome this revision as soon as possible as we aware at the Multiple Births Foundation (MBF) of inconsistency in practice causing great concern for women and potentially increasing the incidence of mortality and morbidity so guidance is urgently needed.		
Baby Lifeline: The Mother & Baby Charity	4	82	if sepsis and pyrexia are going to be considered separately, need to define when pyrexia is not sepsis	Thank you for your comment. The definitions of pyrexia and sepsis used in the review questions will be discussed and agreed by the Guideline Committee during development.	Obstetric
The Division of Women's Health, King's College, London	4	83	Malposition needs clarifying (face presentation not OP)	Thank you for your comment. Malposition was not prioritised for inclusion in the scope of the guideline.	Obstetric
The Royal College of Midwives	4	84	It is unclear why breech presentation is included in this scope, when it is covered in other guidance.	Thank you for your comment. In light of stakeholder feedback and in recognition that other NICE guidelines (caesarean section (CG132) and inducing labour (CG70)) contain recommendations regarding planned mode of birth for breech presentation identified antenatally, the review questions have been amended. The focus in this guideline will be optimal mode of birth (emergency caesarean section or continuation of labour) for women with breech presenting in the first or second stage of labour. The Guideline Committee is also aware of the recommendations on external cephalic version in the NICE guideline on antenatal care for uncomplicated pregnancies (CG62) and the RCOG Green-top Guidelines on	Obstetric

				external cephalic version and management of breech presentation (currently being updated).	
The Division of Women's Health, King's College, London	4	87	Care of women during vaginal birth after a previous caesarean section" is unclear. Do they mean the care during labour (however it ends), or just the second and third stage of vaginal birth after trial of labour after CS.	Thank you for your comment. This is now covered under women with previous caesarean section. The proposed review question focuses on management of the first and second stages of labour.	Obstetric
The Division of Women's Health, King's College, London	4	88	Large for dates is controversial. USS are less accurate at estimating fetal size in the third trimester. How large is large for dates? "care of women with a small-for-dates baby or a large-for-dates baby" is unclear, as I think there is reference to this in antenatal and induction guidelines – or at least the link should be made. Is it just care in labour?	Thank you for your comment. This has been amended to take account of existing NICE guidelines that cover aspects of care for women with small- and large-for gestational age babies. The proposed review question for the topic of large-for-gestational age babies will focus on optimal mode of birth (emergency caesarean section or continuation of labour).	Obstetric
BSIR	4	93	I presume the early involvement of Interventional Radiologists in the management of postpartum haemorrhage will be covered as part of the update of care of women who have a postpartum haemorrhage?	Thank you for your comment. Care of women who have a postpartum haemorrhage will be incorporated into this guideline. This means that the corresponding material in the NICE guideline on intrapartum care for healthy women and babies (CG190) will be moved into this guideline without making any changes.	Obstetric
Royal College of Obstetricians and Gynaecologists	4	93	The scope lists some conditions that will be covered by incorporation from or updating of the NICE guideline on intrapartum care. Care of women with postpartum haemorrhage is covered in an RCOG GTG that is currently being updated – might be worth stating in the scope that guidance from other sources may be incorporated as required.	Thank you for your comment. Care of women who have a postpartum haemorrhage will be incorporated into this guideline. This means that the corresponding material in the NICE guideline on intrapartum care for healthy women and babies (CG190) will be moved into this guideline without making any changes. Although some topics have been excluded from this guideline because of the existence of RCOG Green-top	Obstetric

				Guidelines, NICE guidelines would not typically incorporate RCOG recommendations, but rather signpost where required.	
London Labour Ward Leads Group	4	94	Monitoring during labour including management when cardiotocography is abnormal This order of the words seems to make more sense	Thank you for your comment. The text has been amended to state that details of review questions related to fetal monitoring in the NICE guideline on intrapartum care for healthy women and babies (CG190), and recommendations that will be affected, will be presented in an addendum to the scope following stakeholder consultation on the proposed update	Obstetric
The Division of Women's Health, King's College, London	4	95	I am unclear here whether 'incorporation' means linking up, or redoing entirely, or redoing looking at high risk populations. The three areas were covered anew in IPC 2014. This is particularly important regarding the monitoring or 'management when cardiotocography is abnormal'. Is the CTG interpretation going to be of 'all', 'low risk with a CTG', or 'high risk with a CTG'? Is the CTG a screening or diagnostic test? Does it work differently in low and high risk populations? Will the analysis of 'lower' risk that's been done recently be repeated with equal rigor for high risk?	Thank you for your comment. This section has been amended for clarity. Care of women with delay in the third stage of labour (retained placenta) and care of women who have a postpartum haemorrhage will be incorporated into this guideline. This means that the corresponding material in the NICE guideline on intrapartum care for healthy women and babies (CG190) will be moved into this guideline without making any changes. Fetal monitoring during labour (including management when cardiotocography is abnormal) will be updated for low- and high-risk populations by the obstetric complications guideline committee augmented by co-opted members with an interest and experience in fetal monitoring.	Obstetric
Ferring Pharmaceuticals Ltd	4	96	**Areas that will not be covered** – It is suggested to state under this section - Women whose labour is induced (covered in: Induction of labour | Guidance and guidelines | NICE)	Thank you for your comment. Amendments have been made to the scope to clarify that women who are in spontaneous or induced labour are within the scope of this guideline. Recommendations will be considered regarding	Medical and obstetric

				management of their medical condition or obstetric complication rather than on induction procedure.	
Association for Improvements in the Maternity Services	4	General	**Exclusion of Cases covered by Green Top Guidelines**	Thank you for your comment. Please see response to Comment 137.	Medical and obstetric
Baby Lifeline: The Mother & Baby Charity	5	113	Musculoskeletal disorders & back problems: These women may be high anaesthetic risk	Thank you for your comment. It is recognised that the care of women with musculoskeletal disorders and back problems represents a point of consideration. However, because adverse outcomes do not predominately lead to mortality this area was not prioritised for inclusion in the guideline.	Medical
Baby Lifeline: The Mother & Baby Charity	5	115	Women with previous uterine surgery have higher risk of PPH (UKOSS) – so why are they excluded?	Thank you for your comment. Following stakeholder consultation this population was added to the scope.	Obstetric
Royal College of Obstetricians and Gynaecologists	5	117	Epilepsy in pregnancy was specifically mentioned in the 'Key topic-specific messages for care' section of the last Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012. The RCOG Guidelines Committee is currently developing a Green-top guideline on the management of epilepsy in pregnancy; it will be important to ensure that the intrapartum care of women with epilepsy is adequately covered in this guidance.	Thank you for your comment. It was considered that the emphasis of care for women with epilepsy is in the preconception and antenatal periods and that guidance on intrapartum care for women with epilepsy would be best placed in the NICE guideline on epilepsies (CG137). NICE will consider how best to address this area in future.	Medical
Baby Lifeline: The Mother & Baby Charity	5	118	Why is multiple sclerosis excluded? What about myasthenia gravis and other myopathies?	Thank you for your comment. Regarding the topic of multiple sclerosis, NICE will consider how best to address this area in future. Myasthenia gravis and other myopathies are not	Medical

				included in the scope because of the relatively few women that would be affected.	
The Division of Women's Health, King's College, London	5	129	Is it wise to exclude areas covered by greentop guidance? Should the link be made in the nice guidance to lead the reader to the green top?	Thank you for your comment. Given the breadth of the topic as a whole, areas needed to be prioritised for inclusion in the scope of this guideline. The rationale for each exclusion, and cross-references to other guidelines (such as RCOG Green-top Guidelines) that cover the excluded areas, is now provided in a table in Section 2.3 of the scope for clarity.	Medical and obstetric
The Division of Women's Health, King's College, London	5	129	It seems an oddity to include shoulder dystocia in the new guidelines but then exclude cord prolapse due to RCOG. A consistent approach would be better	Thank you for your comment. Shoulder dystocia has been removed from the scope in response to stakeholder feedback.	Obstetric
Baby Lifeline: The Mother & Baby Charity	6	141	If women having planned sections for anything other than medical conditions are excluded, the majority of those having CS for high risk of haemorrhage are excluded but are high risk by the definition used?	Thank you for your comment. The scope has been amended following stakeholder feedback and this population is now included.	Medical and obstetric
The Division of Women's Health, King's College, London	6	141-154	If these are all excluded, medical conditions are separate, preterm birth etc. have their own guidance is there a need for high risk intrapartum care guidelines?	Thank you for your comment. The remit for guidance on the high-risk population was received from the Department of Health. This section has since been amended to more accurately reflect the intended population.	Obstetric
Baby Lifeline: The Mother & Baby Charity	6	155	Women with social and mental issues will be excluded but these will include the majority if not ALL women who have received no antenatal care	Thank you for your comment. Whilst mental health issues might underlie the difficult personal and social circumstances experienced by some women who have received no antenatal care, mental illness and social needs will not be the only reasons for missing antenatal care for all these women. Regarding the issues of mental	Medical and obstetric

				health and complex social factors during labour and birth, NICE will consider how best to address these areas in future.	
Baby Lifeline: The Mother & Baby Charity	6	155	See comment above about excluding/not women with social circumstances.	Thank you for your comment. Regarding the issue of complex social factors during labour and birth, NICE will consider how best to address this area in future. These are broader issues which are pertinent to all births not just those of women with medical conditions or obstetric complications.	Medical and obstetric
Baby Lifeline: The Mother & Baby Charity	6	164	Women with cardiac disease: A missing question is 'Is regional or general anaesthesia safer for women requiring anaesthesia with cardiac disease	Thank you for comment. This question has been added to the scope as suggested.	Medical
Royal College of Obstetricians and Gynaecologists	6	164 - 287	'Key issues and questions'. We agree that most of the key issues and questions are relevant and clinically important. We are just a bit concerned that the questions lack structure and seem a bit random. Why, for example do we ask 'How should fetal monitoring be managed for women who are at increased risk of haemorrhage because of non-thrombophilic haematological disorders?', yet we don't ask this question for women with platelet disorders.	Thank you for your comment. The key areas to be covered in the scope and the proposed review questions have been refined in the revised scope. In particular, amendments have been made to clarify that women with platelet disorders will be considered as part of the population of women with haemostatic disorders.	Medical
The Royal College of Anaesthetists	7	167	This section ought to cover staffing levels of maternity units taking such patients and vital sign monitoring e.g. MEOWS scoring and the frequency of monitoring.	Thank you for your comment. Staffing levels are outside the remit of the guideline. However, the review questions will cover aspects of maternal observation including the frequency of such observations.	Medical and obstetric
London Labour Ward Leads	7	174-184	It would be useful to add recommendations for which types of cardiac disease should be	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for	Medical

Group			managed in a tertiary unit	healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline. There are other areas of the scope, however, where the Guideline Committee will be expected to consider stratification of risk for women with cardiac disease, for example, which women with cardiac disease should be offered elective caesarean section and which cardiac conditions require additional fluid balance monitoring or management during labour.	
Baby Lifeline: The Mother & Baby Charity	7	177	We know that systemic narcotics provide predominately sedation NOT analgesia in labour. Therefore the question must either 'Does effective analgesia reduce the risk of bad outcomes for mother & baby in women with cardiac disease' or 'what is the safety of regional analgesia compared to systemic narcotic sedation in these women'	Thank you for your comment. The proposed review question has been amended to "What is the effectiveness and safety of regional analgesia compared with systemic narcotic opioid analgesia for women with cardiac disease who are in labour?"	Medical
Royal College of Obstetricians and Gynaecologists	7	179	We feel that the section 'How should the second stage of labour be managed for women with cardiac disease?' should also include the first stage of labour.	Thank you for your comment. The review questions will be discussed and refined by the Guideline Committee when guideline development begins. This point will be considered for inclusion in the review protocol, although for the moment the proposed review question is how should the third stage of labour be managed.	Medical
Baby Lifeline: The Mother & Baby Charity	7	185	Women with respiratory disease: Why is only asthma considered? What about women with cystic fibrosis – when increasing numbers are surviving to reproductive age and	Thank you for your comment. As women with cystic fibrosis represent a small percentage of the population of women giving birth, this area was not prioritised for inclusion in the scope.	Medical

			reproducing?		
British Maternal and Fetal Medicine Society	7	189	Its not just asthmatic women who may be on long term steroids – this may be applicable to other groups of patients	Thank you for your comment. In response to this and comments from other stakeholders, amendments have been made to clarify that intrapartum care for women with asthma and women receiving long-term steroid medication for any condition will be covered as separate key areas.	Medical
Royal College of Obstetricians and Gynaecologists	7	191 - 198	Of note, the RCOG Guidelines Committee has commissioned a guideline relating to bleeding disorders in pregnancy that will address the care of these women in labour.	Thank you for your comment. Although the RCOG has commissioned a guideline relating to bleeding disorders, agreement has not yet been reached about which topics are to be covered given that it is in an early stage of development. Therefore, this population was prioritised for inclusion in this NICE guideline.	Medical
Baby Lifeline: The Mother & Baby Charity	8	199	Does this refer to women who have both subarachnoid haemorrhage/ a-v malformations and platelet disorders, if so why? The safety of regional opposed to general anaesthesia should be considered. Missing Question: Management of women with or suspected of having raised intracranial pressure Review Q for high risk women without medical disorders	Thank you for your comment. An amendment has been made to separate the issues related to platelet disorders from those associated with subarachnoid haemorrhage and/or arterio-venous malformations of the brain. Women with platelet disorders are now included in the same group as women with non-thrombophilic haematological disorders. Similar amendments have been made to the proposed review questions. As raised intracranial pressure affects only a very small number of women in pregnancy this area was not prioritised for inclusion in the guideline.	Medical
British Maternal and Fetal	8	199-203	Is the SAH/AVM prior to pregnancy/during pregnancy/post coiling etc	Thank you for your comment. An amendment has been made to clarify that it is "women with a	Medical

Medicine Society				history of subarachnoid haemorrhage or arterio-venous malformation of the brain".	
Royal College of Obstetricians and Gynaecologists	8	201-203	We feel that the section 'How should the second stage of labour be managed for women with subarachnoid haemorrhage and/or arterio-venous malformations of the brain and platelet disorders?' should also include the first stage of labour.	Thank you for your comment. Given that the guideline cannot cover all aspects of care, the time that women are most at risk was prioritised for inclusion, i.e. the second stage of labour only.	Medical
Royal College of Obstetricians and Gynaecologists	8	204	Q15. The important aspect here is whether fluid balance is optimal or not. Hence suggest rewording as in 'what is the most effective treatment for achieving optimal fluid balance'	Thank you for your comment. This review question has been amended following stakeholder feedback and will be further refined by the Guideline Committee when development begins.	Medical
British Maternal and Fetal Medicine Society	8	212-221	Is obesity going to be divided into the different classes – as the risk/management surgical challenges are very different in a woman with a BMI of 35 compared to one of 55	Thank you for your comment. This level of detail will be discussed when the Guideline Committee convenes to develop review protocols.	Medical
London Labour Ward Leads Group	8	216	To predict mode of birth? Not sure a scan can predict mode of birth. To detect malpresentation by scan could be important in obese women where abdominal palpation is more difficult.	Thank you for your comment. The review question has been amended following stakeholder feedback and no longer refers to the prediction of mode of birth. A review question regarding assessment of fetal presentation in women with obesity has been added to the scope.	Medical
The Royal College of Anaesthetists	8	218	Weight loss interventions would seem logical - maybe this document also need to reflect on life-style issues to reduce the impact on such high risk patients - e.g. exercise/calorie intake/ health education?	Thank you for your comment. Please refer to the existing NICE guidance on weight management before, during and after pregnancy (PH27) for recommendations relating to weight during pregnancy.	Medical

The Royal College of Anaesthetists	9	226	Frequency of observations (e.g. 1 or 4 hourly) should be added to this section.	Thank you for your comment. The proposed review question has been amended as suggested.	Obstetric
Baby Lifeline: The Mother & Baby Charity	9	228	We know that regional analgesia increases the risk of instrumental delivery and prolongs the second stage of labour although most of this evidence comes from low risk/ mixed populations.	Thank you for your comment. Although the majority of evidence is expected to lie in the low-risk population as suggested, this question is relevant for women who fall in the high risk population also.	Obstetric
Royal College of Obstetricians and Gynaecologists	9	230	Of note, RCOG Green-top guideline 37a covers thromboprophylaxis including women at high risk – NICE might be able to incorporate the guidance from the RCOG document (which was updated April 2015).	Thank you for your comment. It was decided that the review question relating to thromboprophylaxis would be removed from the scope as it is adequately discussed within various existing condition-specific maternity guidelines as well as in the RCOG Green-top Guideline on thrombosis and embolism during pregnancy and the puerperium.	Obstetric
Royal College of Obstetricians and Gynaecologists	9	235-248	It would be helpful to consider pyrexia immediately before sepsis Some of the points in this section (29-36) are addressed and covered in Green top guideline no 64a, section 11.	Thank you for your comment. The order of the questions has been changed so pyrexia is followed immediately by sepsis. The Guideline Committee is aware of the RCOG Green-top Guideline on bacterial sepsis in pregnancy but it was considered important to prioritise this for inclusion in the NCIE guideline.	Obstetric
British Maternal and Fetal Medicine Society	9	235-248 and 253-257	Is it not more sensible to cover sepsis and pyrexia together?	Thank you for your comment. The order of the questions has been changed so that pyrexia is followed immediately by sepsis although these topics will be covered separately.	Obstetric
British Maternal and Fetal Medicine Society	9	249-252	Is this not covered in the RCOG Green Top shoulder dystocia guideline	Thank you for your comment. Shoulder dystocia has been removed from the scope in response to stakeholder feedback.	Obstetric

Royal College of Obstetricians and Gynaecologists	9	250	Q37 and 38 are already addressed in RCOG Green-top guideline no 42.	Thank you for your comment. Shoulder dystocia has been removed from the scope in response to stakeholder feedback.	Obstetric
British Maternal and Fetal Medicine Society	10	255-256	should include a discussion of the fact that the FBS result can be falsely reassuring with women with pyrexia in labour as sepsis can present insidiously and be rapidly progressive. Also differing definitions of what is a significant pyrexia are common – the 'pyrexia needs to be clearly defined	Thank you for your comment. The definition of pyrexia will be discussed and agreed with the Guideline Committee during development. These points will be passed on for consideration at that time.	Obstetric
British Maternal and Fetal Medicine Society	10	259-263	Will advice be gestation dependent?	Thank you for your comment. Following comments from stakeholders, an amendment was made to include preterm babies within the scope of the medical and obstetric streams of this scope. When convened, the Guideline Committee will develop protocols for each review question and decide whether advice by gestational age is appropriate.	Medical and obstetric
Royal College of Obstetricians and Gynaecologists	10	259-263	Of note, breech presentation in labour (points 42-43) is covered in RCOG Green-top guideline number 20b (and that this guideline is currently being updated).	Thank you for your comment. In light of stakeholder feedback and in recognition that other NICE guidelines (caesarean section (CG132) and inducing labour (CG70)) contain recommendations regarding planned mode of birth for breech presentation identified antenatally, the review questions have been amended. The focus in this guideline will be optimal mode of birth (emergency caesarean section or continuation of labour) for women with breech presenting in the first or second stage of labour. The Guideline Committee is also	Obstetric

				aware of the recommendations on external cephalic version in the NICE guideline on antenatal care for uncomplicated pregnancies (CG62) and the RCOG Green-top Guidelines on external cephalic version and management of breech presentation (currently being updated).	
The Division of Women's Health, King's College, London	10	260	Suggest the management of singleton term breech pregnancies should be divided into two groups: 1. breech presentation diagnosed prior to labour and 2. diagnosed during labour. Hannah et el (2000) findings only apply to breech presentation diagnosed prior to the onset of labour.	Thank you for your comment. In light of stakeholder feedback and in recognition that other NICE guidelines (caesarean section (CG132) and inducing labour (CG70)) contain recommendations regarding planned mode of birth for breech presentation identified antenatally, the review questions have been amended. The focus in this guideline will be optimal mode of birth (emergency caesarean section or continuation of labour) for women with breech presenting in the first or second stage of labour. The Guideline Committee is also aware of the recommendations on external cephalic version in the NICE guideline on antenatal care for uncomplicated pregnancies (CG62) and the RCOG Green-top Guidelines on external cephalic version and management of breech presentation (currently being updated).	Obstetric
The Division of Women's Health, King's College, London	10	262	Suggest scope relates to the management of the 1st and 2nd stages of labour for singleton breech presentation at term. Helpful to have one evidenced based guideline for the management of singleton term breech pregnancies, note RCOG breech guidelines currently under review.	Thank you for your comment. In light of stakeholder feedback and in recognition that other NICE guidelines (caesarean section (CG132) and inducing labour (CG70)) contain recommendations regarding planned mode of birth for breech presentation identified antenatally, the review questions have been amended. The focus in this guideline will be	Obstetric

				optimal mode of birth (emergency caesarean section or continuation of labour) for women with breech presenting in the first or second stage of labour. The Guideline Committee is also aware of the recommendations on external cephalic version in the NICE guideline on antenatal care for uncomplicated pregnancies (CG62) and the RCOG Green-top Guidelines on external cephalic version and management of breech presentation (currently being updated).	
Baby Lifeline: The Mother & Baby Charity	10	265	The usual term for haemorrhage before delivery is antepartum: Is this covering bleeding from abnormal placentation, abruption, and trauma?	Thank you for your comment. This was considered but intrapartum and not antepartum haemorrhage is specifically intended. Further details regarding the populations included within this review question will be discussed with the Guideline Committee at the time of protocol development.	Obstetric
British Maternal and Fetal Medicine Society	10	270	seems to refer only to women with one previous section - should this be extended to cover up to three previous sections given NICE's current guidance?	Thank you for your comment. This is now covered under women with previous caesarean section. The proposed review question focuses on management of the first and second stages of labour.	Obstetric
London Labour Ward Leads Group	10	270	Will the guideline also address how to assess suitability for VBAC? And also suitability for IOL or augmentation of labour? These are important questions to be considered.	Thank you for your comment. It is outwith the scope to address the antenatal assessment for suitability for labour or induction as these are already considered in the NICE guidelines on caesarean section (CG132) and inducing labour (CG70). This guideline will be restricted to the intrapartum care of women with previous caesarean section. The proposed review question focuses on management of the first and second stages of labour.	Obstetric

The Royal College of Anaesthetists	10	270	VBAC patients - should there be a requirement to audit the complication rates after VBAC especial 3rd degree tears and subsequent morbidity for the women? We are seeing an increase in this complications as the overall caesarean section rate is falling - not necessarily a good thing (maybe covered in 293 but needs a long term follow up as problems such as incontinence may develop years later).	Thank you for your comment. As the complications described in the comment occur postnatally it is beyond the scope of this intrapartum guideline to consider audit of complication rates. Guidance on the management of perineal tears is covered by the RCOG Green-top Guideline on third- and fourth-degree perineal tears.	Obstetric
Royal College of Obstetricians and Gynaecologists	10	270-274	Women having a vaginal birth after a previous caesarean section – this has been extensively covered in a revised RCOG Green-top guideline that is due to be published in the next couple of months. Q46 and Q47 - As it is impossible to guarantee vaginal delivery, suggest rewording as in 'what is the most appropriate place of birth for women who aim to give birth vaginally?' , as women can only aim to have vaginal birth. It is not a certainty until after the event.	Thank you for your comment. The Guideline Committee is are aware of the recently published RCOG Green-top Guideline on birth after caesarean section. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline.	Obstetric
Baby Lifeline: The Mother & Baby Charity	10	271	Place of birth for woman attempting VBAC: what is the logic in considering a setting for labour where the adverse outcome these women have a higher risk for than the general population (uterine rupture), cannot be managed?	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline.	Obstetric

London Labour Ward Leads Group	10	275	How will “xxxx for dates” be defined? By scan or by abdominal palpation?	Thank you for your comment. The definitions of small- and large-for-gestational age will be agreed by the Guideline Committee at the time of protocol development.	Obstetric
Royal College of Obstetricians and Gynaecologists	10	88 & 275	LGA is interesting as the NICE guideline for Antenatal Care states we should not scan for LGA therefore LGA should not be a condition we see at the time of labour other than diabetics in which case it is covered in the NICE Diabetes in Pregnancy guideline. Of note, the RCOG has a Green-top guideline on the Investigation and management of the small for gestational age fetus (number 31), though intrapartum care is not addressed in detail.	Thank you for your comment. With regard to large-for-gestational-age babies it is acknowledged that the NICE guideline on antenatal care for uncomplicated pregnancies (CG62) states that ultrasound estimation of fetal size for suspected large-for-gestational-age unborn babies should not be undertaken in a low-risk population. Also the guideline on inducing labour (CG70) recommends that induction of labour should not be offered solely because a baby is large-for-gestational-age. This guideline will focus specifically on the optimal mode of birth (emergency caesarean section or continuation of labour) for women with a large-for gestational age baby. Intrapartum care for women with small-for-gestational-age babies is included in the scope. The Guideline Committee is aware of the RCOG Green-top Guideline on investigation and management of the small-for-gestational-age fetus).	Obstetric
Royal College of Paediatrics and Child Health	11	278	”How should the second stage of labour be managed for women with a large-for-dates baby?” This closely overlaps with the risk of shoulder dystocia.	Thank you for your comment The scope was amended following stakeholder feedback and it was agreed that this guideline will focus specifically on the optimal mode of birth (emergency caesarean section or continuation of labour) for women with a large-for gestational	Obstetric

				age baby. However, shoulder dystocia has been removed from the scope in response to stakeholder comments and this is noted in the table of exclusions in Section 2.3 of the scope.	
The Division of Women's Health, King's College, London	11	285	This should fall into the main intrapartum care guidelines and care on receipt of woman to high risk unit should be included instead	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline.	Obstetric
Baby Lifeline: The Mother & Baby Charity	11	288	Missing outcome is type of anaesthesia	Thank you for your comment. Anaesthesia has been added to the list of main outcomes.	Medical and obstetric
Academic Centre for Women's Health, University of Bristol & Southmead Hospital	11	288-90	What about including organisational outcomes here as well (e.g. costs, staff satisfaction with care	Thank you for your comment. Clinical outcomes have been prioritised for review, however, the outcomes suggested in the comment may be considered as part of the health economics review for relevant questions.	Medical and obstetric
The Multiple Births Foundation	11	295	While understanding that the NICE process for guideline development is focussed on the review questions we would like to suggest that the women's experience of the whole management of the pregnancy as well as experience of labour and birth is taken into account in the recommendations. This includes the information provided about options for delivery and basis for advice and consistency of care with good communication	Thank you for your comment. Women's experience of labour and birth (including psychological wellbeing) is included as an outcome to be reviewed during the development of this guideline. Separate review questions have been drafted in the scope for women with medical conditions and those with obstetric complications with the aim of addressing their information needs. The precise issues to be addressed through these review questions will be	Medical and obstetric

			between all health care professionals involved. This is of particular relevance for the group identified as high risk before labour as they are more likely to have specialists other than obstetricians and midwives involved with their care during pregnancy.	clarified by the Guideline Committee. A question regarding multidisciplinary care planning has also been included in the scope for women with existing medical conditions.	
The Royal College of Midwives	11	295	We agree with all the main outcomes to be considered and are particularly pleased to see the inclusion of 'psychological wellbeing'.	Thank you for your comment in support of the outcomes listed in the scope.	Medical and obstetric
Royal College of Paediatrics and Child Health	11	299	Not sure that "type of analgesia" is meaningful as an 'outcome'?	Thank you for your comment. While the type of anaesthesia and/or analgesia may not be pertinent in every review question, in some cases it will be important to consider these and so they have been included in the list of main outcomes.	Medical and obstetric
The Royal College of Midwives	11	General	An important question to include here is 'what is the best method for transfer that causes least upset to the woman?	Thank you for your comment. It has been clarified that the NICE guideline on intrapartum care for healthy women and babies (CG190) has evaluated planned place of birth and indications for transfer to obstetric care. These topics have, therefore, been removed from the scope for this guideline.	Medical and obstetric
Royal College of Paediatrics and Child Health	12	306	This is the issue of maternal separation, being addressed by current initiatives to reduce the rate of admission of term babies. It is not just about those babies needing intensive care. We would therefore say 'admission to a neonatal unit'.	Thank you for your comment. This outcome has been revised to refer to admission to a neonatal unit, rather than specifically a neonatal intensive care unit.	Medical and obstetric
Royal College of Obstetricians and Gynaecologists	12	308	Suggest adding for the baby as for the mother 'other major morbidity specific to the topic'.	Thank you for your comment. This has now been added to the list of outcomes for the baby.	Medical and obstetric

Royal College of Paediatrics and Child Health	14	359	This is unfortunate terminology. The dichotomy of 'low risk' and 'high risk' is artificial; risk lies on a spectrum, and different factors constitute different levels of risk. Furthermore women's interpretation of risk is coloured by the values they place on particular outcomes; for example death is catastrophic but very rare, while significant haemorrhage very rarely places a woman's life at risk, but is quite common. The guidance needs to acknowledge that when risk is identified from a medical or midwifery perspective, that may not be how it is perceived by the woman, and decision making needs to be properly shared.	Thank you for your comment. The risk in the scope of this guideline is attributable to either a medical condition known prior to labour or an obstetric complication arising before or during labour. It is recognised that the term “high risk” may not be synonymous with the frequency and importance of risk attributed by pregnant women. Following several comments from stakeholders, the title of the guideline has been changed to “Intrapartum care for women with existing medical conditions or obstetric complications and their babies”. This avoids reliance on the phrase “high risk women”. The guideline will refer to the shared-decision-making recommendations outlined in the patient experience guideline (CG138), and includes a review question regarding the information needs of women in labour. However, the definition to which the comment specifically relates remained unchanged as it was considered to be accurate.	Medical and obstetric
The Division of Women's Health, King's College, London	14	366-378	In view of the fact the majority of women that die will die in the postnatal period it would seem more sensible to have a medical complications guideline that covers antenatal through to postnatal.	Thank you for your comment. This guideline already has a wide scope to cover, including intrapartum care of women with medical conditions and obstetric complications. The remit of this guideline is principally to examine intrapartum care, but it will consider limited aspects of antenatal care and the immediate peripartum period. Effective intrapartum care should reduce the risks of mortality and morbidity in the postnatal period.	Medical and obstetric
The Division of Women's	16	406	Women’s choice as well as departmental differences	Thank you for your comment. An amendment has been made to the scope to allow for differences	Medical and obstetric

Health, King's College, London				because of women’s preferences.	