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Consultation on draft guideline - Stakeholder comments table
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Stakeholder	Document	Page No	Line No	Comments	Developer's response
Action on Smoking and Health	Guideline	005	013	The antenatal referral form should capture information on the woman's smoking status and also whether her partner or anyone in her household smokes. If a woman has recently quit smoking this should also be captured, so that appropriate relapse prevention support can be offered. This should be clearly recommended in the guideline. Exposure to secondhand tobacco smoke during pregnancy and after birth increases the risk of sudden infant death, stillbirth, congenital malformations, low birth weight and respiratory illnesses.[i] Evidence has shown that women who live with a smoker are six times more likely to smoke throughout pregnancy, and those who live with a smoker and manage to quit are more likely to relapse to smoking once the baby is born.[ii] An estimated 20% of women are also exposed to secondhand smoke in the home throughout their pregnancy, making it harder for them to quit and leading to many of the same adverse birth outcomes experienced by women who smoke.[iii] NICE PH26 recommends that partners who smoke should be given clear advice about the harms of secondhand smoke to the pregnant woman and the baby and informed that they should not smoke around the pregnant woman or baby, especially in the home or car.[iv] It is therefore essential that	Thank you for this comment which the committee discussed. We have added that early pregnancy information given alongside the referral should include information on smoking cessation and we have also made a reference to the NICE guideline PH26 which you also refer to. Later on in the guideline, we have also added that history taking should also include capturing if the woman's partner smokes and referral should be offered to both for NHS Stop Smoking Services.

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				healthcare professionals carrying out antenatal appointments are informed about the smoking status of pregnant women and their partners/household members.	
Action on Smoking and Health	Guideline	006	017	The guideline should specifically identify smoking and the need for smoking cessation and/or relapse prevention support as a factor which could indicate a need for "additional or longer antenatal appointments". Pregnant women who smoke are more likely to need more intensive antenatal care throughout pregnancy and experience multiple risk factors. Pregnant women who have recently quit smoking are vulnerable to relapse postpartum and need to be identified so that postnatal care can be offered. Available evidence shows that complex social factors are twice as prevalent among women who are smokers at the time of their first booking appointment (22.4%) than non-smokers (11.3%).[v] Complex social factors include poverty, homelessness, substance misuse, and being aged under 20.[vi] Booking data from 2017 shows that nearly a third of women aged under 18 continue to smoke in their first pregnancy, rising to almost 40% for those booking for subsequent pregnancy in the same age group.[vii] It is well established that smoking during pregnancy is a risk factor for spontaneous abortions, stillbirth, preterm births, asthma, sudden infant deaths, obesity, diabetes, offspring psychological problems, including	Thank you for this comment. The committee agreed not to specify all the various scenarios where additional or longer appointments might be needed based on medical, emotional or social reasons. The guideline however makes it clear that information on importance of smoking cessation should be provided from the first contact with antenatal services, the smoking status should be enquired and support for smoking cessation should be provided. The guideline recommendations should also capture the other vulnerabilities that are prevalent in women who smoke at the time of their booking appointment.

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				attention deficits, cognitive functioning, and conduct problems.[i] [viii] [ix] Additionally, pregnant women who smoke themselves experience complications such as premature rupture of the amniotic membrane, incompetent cervix, preeclampsia, and pregnancy-induced hypertension.[x]	
Action on Smoking and Health	Guideline	007	010	This guideline should specifically reference the importance of delivering advice about smoking and smokefree homes to mothers and their partners or household members during antenatal appointments. Living with smoking partners/household members makes it harder for pregnant women to quit and risks exposing mothers and babies to secondhand smoke.[xi] Women who have quit smoking during pregnancy think that cessation support for partners is critical for helping mothers to stay smokefree after the birth but is often overlooked by health professionals.[xii] Evidence suggests that nearly half of women who quit smoking during pregnancy relapse after their baby's birth.[xiii] There is no risk-free level of secondhand smoke exposure, especially for children,[xiv] and growing up in a smoking household nearly triples the likelihood that a child will become a smoker themselves.[xv]	Thank you for this comment. We have added partners to the recommendation on offering referral to the NHS smoking cessation services. The guideline includes various recommendations in relation to offering information and advice related to smoking and we have made a reference to the NICE guideline PH26.

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				NICE PH26[iv] recommends that partners who smoke should be given clear advice about the harms of secondhand smoke to pregnant women and babies. The NHS Long Term Plan's commitment to include pregnant women's partners in the tobacco dependence treatment pathway recognises that women's home environments have a crucial impact on their smoking.[xvi]	
Action on Smoking and Health	Guideline	010	008	This guideline should explicitly recommend that Carbon Monoxide (CO) testing is offered to all pregnant women at their antenatal booking appointment, with the outcome recorded. This is recommended in Version 2 of the Saving Babies' Lives Care Bundle (SBLCBv2)[xvii] and NICE PH26.[iv] A CO test is an immediate and non-invasive biochemical method for helping to assess whether or not someone smokes or has been exposed to CO from other sources such as such as faulty gas boilers and exhaust fumes.[xviii]It should be used to facilitate the referral of smokers to specialist stop smoking support.	Thank you for this comment. This issue was not in the scope of this guideline and evidence on it was not reviewed, thus no comment have been made.
Action on Smoking and Health	Guideline	010	019	This guideline should explicitly recommend that CO testing is offered to all pregnant women and their partners (if they are in attendance) at the first face-to-face antenatal appointment, as per the SBLCBv2[xvii] and NICE PH26.[iv] Babies exposed to CO during pregnancy are at risk of stillbirth, low birth weight, premature birth, and miscarriage[xix], so it is vital that pregnant women	Thank you for this comment. This issue was not in the scope of this guideline and evidence on it was not reviewed, thus no comment have been made.

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				are routinely tested for CO, receive advice on quitting and a referral to stop smoking support. CO testing is an effective tool for identifying pregnant smokers, facilitating referral to stop smoking support, and increasing quit rates.[xx] [xxi] Evidence from the BabyClear programme shows that introducing 'opt-out' referrals with CO identification of smokers at 12-week dating ultrasound scan appointments increased the numbers of pregnant smokers setting quit dates and reporting smoking cessation.[xxii] Evidence also shows that pregnant women are generally happy to accept CO screening as part of their routine antenatal care and are often curious about their result. [xxiii] [xxiv]	
Action on Smoking and Health	Guideline	012	012	Smoking is a known risk factor for venous thromboembolism (VTE) during pregnancy and up to six weeks following pregnancy.[xxv] VTE is a leading cause of deaths and disability in the UK.[xxvi] Failure to diagnose a case of VTE may result in a patient not receiving the correct treatment and potentially developing post-thrombotic syndrome or a fatal post embolism as a result.[xxvi] This guideline should recommend that pregnant women who smoke are referred to stop smoking support to reduce their risk of VTE.	Thank you for this comment. Smoking during pregnancy is a risk factor for various things and these have not been discussed in the guideline, instead a reference was made to the NICE guideline on stopping smoking during pregnancy. Importance of smoking cessation is evidence by the various references to this in the guideline.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	General	General	AIMS is disappointed there is no reference in the guidelines to building a relationship based on trust and mutual respect with the care provider and the woman, in line with the Continuity of Carer model for maternity services.	Thank you for this comment. The guideline gives a definition of 'continuity of carer' (there is a direct link from the recommendation to the definition) and the first sentence of the definition is: "Having continuity of carer means that a trusting relationship can be developed between the woman and the healthcare professional who cares for her."
Association for Improvements in the Maternity Services (AIMS)	Guideline	General	General	AIMS notices the use of medical terminology which is not helpful for service users who may have no medical knowledge and would find the guidelines challenging. We ask that you consider clarifying medical terminology.	Thank you for this comment. NICE guidelines are aimed at professionals as well as service users and the editorial team at NICE together with the committee have tried to find a balance to meet the needs of the wide audience. Revisions have been made where considered appropriate, for example, the language used in Table 1 about the different pharmacological options for nausea and vomiting in pregnancy have been revised. NICE provides a glossary of terms on their website explaining many of the potentially more complicated words.
Association for Improvements in the	Guideline	General	General	AIMS is concerned with the tone of the guidelines, in that they are prescriptive with no mention of the woman's preferences. The language should be more consistent in using the terms 'offer','discuss', 'explain' throughout the document. There is no mention of informed consent or	Thank you for this comment. The language has been revised throughout the guideline as suggested. The committee also added a recommendation to make it clear that when offering any interventions, tests, examinations or

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Maternity Services (AIMS)				confidentiality and the woman having the right to decline any suggestion. AIMS would like to see an explanation of the special circumstances, why and how they risk assess, and clear implications discussed consistently throughout the guidelines. There is also no mention of making a diagnosis for common problems. Referrals are made without any consideration of the woman's preferences and informed consent.	procedures, the risks, benefits and implications should be discussed with the woman to allow for an informed decision, including the right to decline.
Association for Improvements in the Maternity Services (AIMS)	Guideline	General	General	The guidelines are found to be inconsistent in that comparisons are used to illustrate the advantages and disadvantages of taking medication for nausea and vomiting, but not used for any other medications suggested for other ailments.	Thank you for this comment. The evidence on non-pharmacological and pharmacological treatment for nausea and vomiting in pregnancy identified various different pharmacological treatments but none of the medicines were clearly better than others in terms of effectiveness. Therefore, choosing the medicine can be strongly dependent on preference of individuals, weighing the different advantages and disadvantages of the different medications, and a table was thought to facilitate the decision making. Similar tables could be valuable for other conditions where there is a preference sensitive decision point, however, nausea and vomiting in pregnancy was prioritised considering the number of different options.
Association for Improvements in	Guideline	024 - 025 - 026	whole pages	AIMS comments that it's strange there are tables only for this and nowhere else in the guidelines.	Thank you for this comment. The evidence on non-pharmacological and pharmacological treatment for nausea and vomiting in pregnancy identified various different pharmacological

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the Maternity Services (AIMS)					treatments but none of the medicines were clearly better than others in terms of effectiveness. Therefore, choosing the medicine can be strongly dependent on preference of individuals, weighing the different advantages and disadvantages of the different medications, and a table was thought to facilitate the decision making. Similar tables could be valuable for other conditions where there is a preference sensitive decision point, however, nausea and vomiting in pregnancy was prioritised considering the number of different options.
Association for Improvements in the Maternity Services (AIMS)	Guideline	001	Box	Please define 'healthy women and their babies' - maybe a reference to how to define 'healthy' in these guidelines. What about those women who do not 'fit' in this box?	Thank you for this comment. We have revised the text as we agree that it is ambiguous and not helpful. This guideline covers routine antenatal care and there are women who may not be 'healthy' for whom routine antenatal care is sufficient.
Association for Improvements in the Maternit	Guideline	005	Box	Please reword the first sentence: 'People have the right and should be involved in discussion and supported to make informed decisions about their care'.	Thank you for this comment. This is a standard text used by NICE and we have passed your comment to NICE.

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y Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	005	004	Please consider changing the word 'starting' to 'offering'.	Thank you for this comment. This section is about starting antenatal care and we have kept the wording as it is. However, we have revised the language throughout the guideline to emphasise the choice that the women have on the care.
Association for Improvements in the Maternity Services (AIMS)	Guideline	005	009	We find the description 'easy-to-complete' not clear, vague and prescriptive.	Thank you for this comment. Many women self refer themselves to antenatal care and the committee wanted to recommend that service providers ensure that the referral form is accessible and in a format that all women can complete. It was difficult for the committee to be more specific, however, it was thought to be important that this point is made explicitly so that service providers give consideration to the accessibility of the referral forms.
Association for Improvements in the	Guideline	005	013	Please consider changing 'to start' to 'being offered'.	Thank you for this comment. This section is about starting antenatal care and we have kept the wording as it is. However, we have revised the language throughout the guideline to

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Maternity Services (AIMS)					emphasise the choice that the women have on the care.
Association for Improvements in the Maternity Services (AIMS)	Guideline	006	012 - 015	It would be useful to reference the justification for the number of suggested antenatal visits here, and not further on down the document.	Thank you for this comment. In the final published web version of the guideline, the 'Why the committee made the recommendations' will be available to read underneath the recommendation. Unfortunately in the consultation version this is not the case.
Association for Improvements in the Maternity Services (AIMS)	Guideline	006	013 - 015	AIMS is asking to for the language used to more accessible to all and avoid medical language where possible.	Thank you for this comment. NICE guidelines are aimed at professionals as well as service users and the editorial team at NICE together with the committee have tried to find a balance to meet the needs of the wide audience. Revisions have been made where considered appropriate, for example, the language used in Table 1 about the different pharmacological options for nausea and vomiting in pregnancy have been revised. NICE provides a glossary of terms on their website explaining many of the potentially more complicated words.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	006	023	We suggest changing the word 'reliable' to 'independent', and adding 'any other support, including emotional, that the woman may wish to have with her'.	Thank you for this comment, we have revised the wording of the recommendation to state that the interpreter should be independent to the woman. Other support that the woman wishes to include in her care is covered by other recommendations in the guideline.
Association for Improvements in the Maternity Services (AIMS)	Guideline	007	001	AIMS welcomes the reference to continuity of carer and suggests moving this important point to the top of the section.	Thank you for this comment. We have carefully considered the order of the recommendations and received feedback from stakeholders that the guideline flows well, so we have not changed the order.
Association for Improvements in the Maternity Services (AIMS)	Guideline	007	004	AIMS suggests changing 'partner' to 'partner of her choice'.	Thank you for this comment. The word 'partner' has been defined in the 'terms used' section of the guideline which makes it clear it's her partner of choice.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	007	006	AIMS suggests changing 'welcome' to 'encouraged'.	Thank you for this comment. The committee recognised that women's home and family circumstances vary, and it is up to the woman to decide who she may want to involve in her antenatal care. The committee discussed that many women may be in coercive relationships and experience domestic abuse and the woman's autonomy and safety are paramount as this guideline is first and foremost for the woman. The committee discussed that if the woman did not wish to bring a partner, then this should be respected.
Association for Improvements in the Maternity Services (AIMS)	Guideline	008	005	Please give an explanation why this information is relevant.	Thank you for this comment. The justification for the recommendation is provided in the 'Why the committee made the recommendations' section as well as in the relevant evidence reports. However, if you mean that the woman should be explained why this information is relevant, we think that this does not need to be explained separately. This is part of good practice and general communication and care provision by any healthcare professional and not specific to antenatal care.
Association for	Guideline	008	017	AIMS suggests adding to this bullet point to 'her home situation and social support network'.	Thank you for this comment, we have amended the text.

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Improvements in the Maternity Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	009	001-019	AIMS questions the rationale behind publishing these numbers in relation to the 2020 MBRRACE-UK report, as these figures may change before these updated NICE Guidelines are issued?	Thank you for this comment. It was considered important to highlight the stark disparities in these outcomes by including the figures. The recommendation references the specific report so it should be clear what these figures are based on. If the relative risks will change considerably in the next iterations, NICE can update the figures as needed. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Association for Improvements in the Maternity	Guideline	009	002	Please explain what 'may need closer monitoring' means. AIMS suggests 'offered additional support in the form of …'	Thank you for this comment. Closer monitoring could mean for example additional contacts or lower threshold for acting when there are concerns. However, the committee agreed that additional support may also be relevant have added this to the recommendation.

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Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	009	020	Offer a discussion around smoking and referral, instead of an automatic referral.	Thank you for this comment, we have amended the wording as suggested.
Association for Improvements in the Maternity Services (AIMS)	Guideline	009	023	What does this mean - to 'consider'?	Thank you for this comment. Depending on the situation, a review by a doctor might be appropriate. Because this was not an area that was directly reviewed and it is therefore based on committee consensus of best practice, the recommendation is not stronger than that.
Association for Improvements in the Maternity	Guideline	009	027	AIMS is concerned that information is shared with GP without permission and questions if this is standard practice? Consider rewording to include 'in consultation with the service user'.	Thank you for this comment. The committee amended the wording to say this should be discussed and agreed with the woman.

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Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	009	029	AIMS suggests changing the tone to offer and not just ask.	Thank you for this comment. We think the word 'ask' is probably the right one to use here, as the committee felt that this should be enquired. However, we have tried to amend the tone of this recommendation so that it does not come across as if this issue can be covered by just a blunt question but rather a sensitive discussion.
Association for Improvements in the Maternity Services (AIMS)	Guideline	010	004	Please give an explanation of how this assessment is discussed and carried out.	Thank you for this comment. The UK government guidance the recommendation refers to gives practical guidance for healthcare professionals on how this assessment can be discussed and carried out.
Association for Improvements in the Maternity	Guideline	010	020	AIMS is concerned that no explanation or offer is made to measure height, weight and BMI. There is no acknowledgement of concerns around body image and we suggest a discussion around informed consent and the right to decline is offered.	Thank you for this comment. The committee added a general recommendation about when offering any assessment, intervention or procedure that the benefits, risks and implications are discussed and that the woman is made aware of her right to decline.

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Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	012	001-002	AIMS suggests clarifying the terminology and explaining the assessment.	Thank you for this comment. NICE guidelines are aimed primarily at professionals but also for service users and the editorial team at NICE together with the committee have carefully tried to find a balance to meet the needs of the wide audience but in general NICE guidelines do use medical terms where appropriate. It was not considered necessary to add any further explanation of the assessment of risk factors in the recommendation itself. The guideline in general recommends that communication with women is tailored to their needs and preferences and that the healthcare professional checks that the woman (and her partner) understand the information that has been provided.
Association for Improvements in the Maternity	Guideline	012	014-015	AIMS suggests to give an explanation of GD and why/how they risk assess, and the implications.	Thank you for this comment. NICE guidelines are aimed primarily at professionals but also for service users and the editorial team at NICE together with the committee have carefully tried to find a balance to meet the needs of the wide audience but in general NICE guidelines do use medical terms where appropriate. It was not

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Services (AIMS)					considered necessary to add any further explanation of the assessment of risk factors in the recommendation itself. The guideline recommends that communication with women is tailored to their needs and preferences and that the healthcare professional checks that the woman (and her partner) understand the information that has been provided.
Association for Improvements in the Maternity Services (AIMS)	Guideline	013	001-002	AIMS suggests to give an explanation and why/how they risk assess, and also the implications.	Thank you for this comment. The committee added a general recommendation which states that when offering an assessment, intervention or procedure, the benefits, risks and implications should be discussed with the woman.
Association for Improvements in the Maternity Services (AIMS)	Guideline	013	003	AIMS would like to see an explanation of why aspirin should be taken, the effects, the outcomes, and the dosage.	Thank you for this comment. The recommendation on aspirin take comes from another NICE guideline (Hypertension in pregnancy) which the recommendation refers to and was not reviewed by the antenatal care guideline committee. The evidence base and reasoning underpinning this recommendation can be found in the documentation for the NICE guideline on hypertension in pregnancy.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	014	002	Please provide an explanation of why a risk assessment for growth is done, and the implications.	Thank you for this comment. The committee added a general recommendation which states that when offering an assessment, intervention or procedure, the benefits, risks and implications should be discussed with the woman.
Association for Improvements in the Maternity Services (AIMS)	Guideline	014	006	AIMS is concerned there is no mention of consent before performing an ultrasound.	Thank you for this comment. The recommendation has been revised to say 'offer' rather than 'perform'. The committee also agreed to add a recommendation that emphasises that when offering any examinations or procedure, the benefits, harms and implications should be discussed and that she has the right to decline.
Association for Improvements in the Maternity Services (AIMS)	Guideline	014	009	AIMS would like to see the suggestion that the same midwife carried out the fundal measurement in line with continuity of carer, best practice and for improved accuracy.	Thank you for this comment. Evidence on the effectiveness of continuity of carer was not reviewed by the committee so the committee did not comment anything specific about it but a general recommendation was made about aiming for continuity of carer in line with the NHS Better Births.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	014	019	What is the evidence for this reasoning?	Thank you for this comment. Evidence on the benefits and harms of routine ultrasound after 28 weeks for pregnant women with low-risk pregnancies was reviewed by the committee and based on various randomised controlled trials no benefit was found, therefore the committee agreed that it should not be offered routinely for women with uncomplicated, singleton pregnancies. Evidence review Q provides more details about the evidence and the committee's discussion.
Association for Improvements in the Maternity Services (AIMS)	Guideline	014	021	AIMS is asking for the rationale behind this and questions if it makes a difference?	Thank you for this comment. In retrospective studies, stillbirth has been linked with earlier reduced fetal movements. The committee looked at evidence on the effectiveness of fetal movement monitoring methods or packages and found no evidence of benefit of any particular method or package in reducing stillbirth or adverse outcomes. However, the committee agreed that in general fetal movements should be discussed with women, not least because women often want to discuss it, and women's

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					concerns regarding fetal movements should be asked and discussed.
Association for Improvements in the Maternity Services (AIMS)	Guideline	015	012	Consent must be given before anyone touches someone else's body. An explanation should be given so the woman understands what is going on.	Thank you for this comment. We have amended the wording in the recommendation and we have added a general recommendation that whenever any investigation or procedure is offered, it should be ensured that the benefits, risks and implications are discussed and the woman is aware that she has the right to decline.
Association for Improvements in the Maternity Services (AIMS)	Guideline	015	017	Again there is no mention of gaining consent, explanation or implications.	Thank you for this comment. The recommendation has been revised to say that benefits, harms and implications of the options should be discussed. The committee also made a general recommendation that states that if any intervention or a procedure is offered it should be ensured that benefits, harms and implications are discussed and the woman is made aware that she has the right to decline it.
Association for Improvements in the	Guideline	015	020	AIMS would prefer to see the evidence and an acknowledgement that babies can turn on their own later than 36 weeks gestation. AIMS would like to see reference made to exploring the woman's values and beliefs around vaginal breech birth. Again, there is no mention of gaining consent.	Thank you for this comment. The recommendation has been revised to say that the benefits, harms and implications of all the options (external cephalic version, breech vaginal birth or elective caesarean birth) are discussed

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Maternity Services (AIMS)					and this discussion would presumably include exploring the woman's thoughts around vaginal breech birth as well as discussion about the chance that the baby might spontaneously turn.
Association for Improvements in the Maternity Services (AIMS)	Guideline	016	010-023	AIMS suggests prioritising the bullet points. There is no mention of confidentiality. What is meant by 'group discussions'?	Thank you for this comment. The committee did not think these bullets can be put into an order of priority. A cross-reference to the NICE guideline on patient experience in adult NHS services has been made which covers the issue on confidentiality. Group discussions means for example antenatal classes or group antenatal appointments (offered for certain appointments some areas in current practice), we do not think this needs further explanation.
Association for Improvements in the Maternity Services (AIMS)	Guideline	016	001	AIMS suggests an explanation and discussion of the risks and alternatives.	Thank you for this comment. The recommendation has been revised to say that the benefits, harms and implications of all the options (external cephalic version, breech vaginal birth or elective caesarean birth) are discussed.
Association for	Guideline	016	014	AIMS suggests changing 'information should support shared decision making' to 'information should facilitate supported decision making'.	Thank you for this comment. NICE supports shared decision making and more information

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Improvements in the Maternity Services (AIMS)					about what that entails and what it means is covered on the NICE website: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making
Association for Improvements in the Maternity Services (AIMS)	Guideline	017	008-012	AIMS would like to see a 2-way conversation, sharing healthcare knowledge, exploring and understanding the woman's circumstances, tailoring care to how risk applied to them - more individualised care.	Thank you for this comment. We believe this is captured by the recommendations, which emphasise need to individualise care. For example the recommendations state that the timing, content and delivery of information provision should be tailored according to the woman's needs and preferences. The committee also added a recommendation whish highlights that healthcare professionals should listen to the woman and be responsive to her needs and preferences.
Association for Improvements in the Maternity Services (AIMS)	Guideline	018	whole page	AIMS suggests this section on Information on Antenatal Care should be moved to the beginning of the guidelines.	Thank you for this comment which the committee considered, however, the guideline structure was carefully considered by the committee and the editor and we received feedback from other stakeholders saying the guideline flowed well, therefore, we have decided not to move this section.

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Association for Improvements in the Maternity Services (AIMS)	Guideline	019	019	AIMS requests a link for those women who don't fit the 'healthy women' or 'caesarean birth' boxes. This implies that all women who are not healthy have a caesarean birth. Very poorly worded.	Thank you for this comment. NICE tries to avoid duplicating recommendations on the same issue across different guidelines and instead makes cross-references. In this case, we have made cross-references to other NICE guidelines that already cover planning of place of birth (CG190) and planning of mode of birth (NG192). The two links therefore are not mutually exclusive but cover two different aspects of birth preferences.
Association for Improvements in the Maternity Services (AIMS)	Guideline	019	022	AIMS would like to see a reference to options for pain relief.	Thank you for this comment, this is implicit in the recommendation as well as covered by the recommendation about discussing her birth preferences.
Association for Improvements in the Maternity	Guideline	019	029	AIMS suggests changing the wording from 'baby blues' to 'mood changes'.	Thank you for this comment, we have revised the wording as suggested.

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Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	020	003	AIMS is concerned that risks are repeatedly discussed at every meeting from 36 weeks, at a time when women are already feeling overwhelmed. It is coercive and causes stress and anxiety. AIMS suggests giving an explanation, asking for consent, having the right to refuse and respecting women's wishes.	Thank you for this comment, we have revised the recommendation to be from 28 weeks (instead of 36 weeks) and have revised the wording to "From 36 weeks onwards, as appropriate..."
Association for Improvements in the Maternity Services (AIMS)	Guideline	020	006	AIMS is concerned that induction is discussed at every appointment from 38 weeks, as it seems excessive and coercive.	Thank you for this comment, we have revised the recommendation to say "From 38 weeks".
Association for Improvements in the Maternity	Guideline	021	006	AIMS questions if service users and the public understand the term 'multiparous'?	Thank you for this comment, which we have considered, however, this term is commonly used in NICE maternity guidelines and we have decided to keep it.

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Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	021	020	AIMS suggests 'offer' and not 'give'.	Thank you for this comment, we have revised the wording as suggested.
Association for Improvements in the Maternity Services (AIMS)	Guideline	022	002-004	AIMS questions the validity of this comment.	Thank you for this comment. There was evidence that suggested that going to sleep on one's back was associated with stillbirth and small for gestational age. Therefore, the committee made a recommendation to advise against this and included a practical example how this could be avoided.
Association for Improvements in the Maternity	Guideline	022	011-012	AIMS suggests offering a referral, as suggesting to take ginger can be seen as dismissive and not taking the condition seriously.	Thank you for this comment. The committee have revised the recommendations for interventions of nausea and vomiting in pregnancy in line with other stakeholder comments to better capture that women may attempt various self help techniques, such as

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Services (AIMS)					taking ginger, before seeking medical help. However, many women who seek medical advice for mild to moderate nausea and vomiting in pregnancy might have not tried ginger and some would prefer trying a non-pharmacological interventions and so suggesting trying ginger was recommended for these women. The clinical evidence on ginger suggested that it is effective for some women.
Association for Improvements in the Maternity Services (AIMS)	Guideline	022	016	AIMS questions whether the public understands 'comorbidities'?	Thank you for this comment. We have revised this recommendation and as a result the word comorbidities was removed.
Association for Improvements in the Maternity	Guideline	023	001	Please change to 'Share table 1 to support decision making.'	Thank you for this comment. The table 1 is primarily meant to benefit the healthcare professional in their discussion with the woman, and not a patient decision aid as such, therefore we have not changed the wording.

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Services (AIMS)					
Association for Improvements in the Maternity Services (AIMS)	Guideline	028	001-004	AIMS is concerned there is no mention of making a referral to make a diagnosis.	Thank you for this comment. We have revised this section. The committee concluded after revisiting this topic that diagnosis and management of hyperemesis gravidarum is not in the remit of this guideline which covers routine care and management of some common problems only.
Association for Improvements in the Maternity Services (AIMS)	Guideline	028	012	AIMS suggests changing the word 'tell' to 'offer information'	Thank you for this comment. We have amended the wording to say "advice" to be less blunt. "Offer information" wouldn't quite work because the healthcare professionals need to let the woman know that if she has symptoms this may require further management.
Association for Improvements in the Maternity	Guideline	029	012-016	AIMS suggests this section should be moved.	Thank you for this comment. It is not clear from the comment where this section should be moved or why. We have very carefully considered the order of the recommendations and received feedback from other stakeholders

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Services (AIMS)					saying the guideline flowed well so we have not moved this section.
Association for Improvements in the Maternity Services (AIMS)	Guideline	029	001	AIMS suggests this recommendation includes providing information and offering the referral	Thank you for this comment. The committee have added a recommendation that with any investigation or procedure, its benefits, risks and implications should be discussed with the woman and the woman should be made aware that she has the right to decline.
Association for Improvements in the Maternity Services (AIMS)	Guideline	029	008	AIMS suggests this recommendation includes providing information and offering the referral	Thank you for this comment. As with any intervention, the assumption is that a referral is discussed with the woman so we have not amended the wording in the recommendation.
Association for Improvements in the Maternity	Guideline	038	019	AIMS queries why NICE have mentioned health care disparities amongst women and babies from a black and minority ethnic background and those from deprived areas, and that future research could help to understand the reasons why and what interventions may improve outcomes, yet this was not one of the key research recommendations? AIMS believes that	Thank you for this comment. We agree that research on this is needed, particularly on interventions that might improve outcomes and mitigate these disparities, however, we are only able to make research recommendations on topics we have specifically tried to identify and

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Services (AIMS)				understanding the reasons may help to improve maternity care for these groups of people and research into these disparities is essential.	review evidence on, therefore, no particular research recommendation has been made on this topic, although the committee wanted to address this in the research recommendation about the different models for antenatal care. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Belloost LTD	Evidence review U	General	General	For women with pregnancy-related pelvic girdle pain, referral to primary healthcare such as physiotherapists, chiropractors, osteopaths should be the first step. These services can offer individualised assessment and treatment including manual therapy, exercises and advice. Support aids including crutches and referral to an occupational therapist should be the next step for persistent pain. Disscusion about birth planning to take into account the woman's immobility should be offered. This is of particular importance during these times where pregnant women are more and more isolated due to COVID.	Thank you for this comment. Interventions for pelvic girdle pain have only been recommended where there is supporting evidence available. Discussions around birth planning were not specified in the review protocol so cannot be included in the review.
Belloost LTD	Evidence review U	General	General	Psychological support for women with significant pain and immobility due to PGP should be considered. It is well documented that mental health plays a role in a person's experience of pain. This is also true for PGP. Women are suffering in silence and pre and postnatal depression is at an all-time high as a result of the pandemic. The approach outlined above is purely focused on cost-effectiveness and not the physical and mental wellbeing of women. Isolating women further by recommending no in-person support is a big step in the wrong direction.	Thank you for this comment. This review focused on the clinical interventions to treat pelvic girdle pain in pregnancy and therefore psychological support for pelvic girdle pain or other management beyond the clinical interventions were not considered in this review, although we agree that it is an important topic considering the potentially significant impact the pelvic girdle pain can have on the woman. The

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					committee considered clinical effectiveness evidence as well as cost-effectiveness when making recommendations and their decision is highlighted in detail in the 'Committee's discussion of the evidence' section of evidence review U.
Belloost LTD	Evidence review U	**028**	042-046	We are concerned that this recommendation states that manual therapy is not a useful treatment intervention when you HAVE NOT looked at the full body of evidence available. The studies you have included do not represent what manual therapy for pregnancy-related pelvic girdle pain (PGP) looks like in practice. Foot manipulation studies SHOULD NOT have been included here. It is an insult to manual therapists who specialise in the biomechanics of the spine and pelvis which is paramount for treating PGP. In addition, craniosacral therapists are not primary health care professionals, thus are not qualified to diagnose musculoskeletal problems. This is of vital importance when dealing with patients with PGP as you will read below. We would like to submit a comment in response to Evidence review U - Pelvic girdle pain in pregnancy, in which you concluded the use of manual therapy for the treatment of Pelvic Girdle Pain, will no longer be supported by the NICE guidelines. Of the three studies you have included, only one looks at the use of chiropractic care and or other manual/manipulative therapy to the affected area - biomechanics of the spine and sacroiliac joints. We feel all the available research and the value women receive from treatment during pregnancy has not been considered. It would be negligent to remove manual therapy as a recommended option in the NICE	Thank you for this comment. We have checked the studies you have listed against criteria set in the review protocol. They do not match our protocol so we cannot include them in the review. Reasons for exclusion are as follows: Peterson 2014 - Our protocol specifies that other study designs will be considered for an intervention class only if randomised controlled studies are not available. As we have data from randomised controlled trials for chiropractic intervention included in this review, we cannot include this study design. The population are also not specific to pelvic girdle pain. Bergstrom 2016 - This study does not focus on the effectiveness of any of the interventions

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				guidelines for the treatment of PGP. Below is a list of studies that examine the use of manual therapy for pelvic girdle pain, none of which have yet been included in your analysis. Why have you not included any of these studies in your analysis? Manual therapist both nationally and international help thousands of pregnant women with pelvic girdle pain. We know from first hand experience how much impact it can have on a women's quality of life and mental health. It also may restrict their birth options due to reduced mobility. It would be devastating to remove the use of manual therapy for PGP from the NICE guidelines. From the perspective of the clinician the correct diagnosis of PGP is of vital importance when formulating the correct treatment plan; research shows this. Misdiagnose PGP in the pregnant population is common due to the cross over in symptoms of other lower back pain related conditions. Seeing a qualified, skilled and experienced manual therapist greatly improves the probability of achieving an accurate diagnosis and thus prescribing the appropriate types of hands on care and exercises. We fear these new guidelines will limit the number of women, seeing manual therapists to initiate that first step. More will be left in pain which impacts directly on mental health and birth choices. It is therefore important to assess the full spectrum of research and indeed consult with the women themselves who have benefited in the past before concluding manual therapy is not and effective treatment for PGP. For many it's been a lifeline.	listed in the protocol and cannot be included in the review. Rubinstein 2012 - the population is not specific to pregnant women and therefore outside of the scope. Weis 2020 - this is a systematic review and so the included studies have been checked. Three of their included studies were already included in our review. Other included studies did not match our review protocol. Miles et al. - this is a review of literature and so not an eligible study design. Franke 2017 - this is a systematic review and so the included studies have been checked. They do not meet the criteria in the protocol so cannot be included. Management of backache was excluded in the guideline scope. The committee discussed pelvic girdle pain at length, but without the evidence available they were unable to support and therefore make a recommendation for manual therapy. Please note the 'Committee's discussion of the evidence' section of evidence review U has been updated to better reflect the Committee's decision making.

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				Manual therapy in conjunction with exercise and supportive aids can have a huge positive impact yes, but taking one modality in isolation is very rarely as effective. We know from clinical practice, exercise alone is not effective for the majority of women. And support belts when overused can cause prolonged biomechanical issues. We agree there needs to be more research into the use of manual therapy alone, the data gap in women's health is not an anomaly and there are ethical considerations that mean RCT's on pregnant women have some serious negative consequences for those in the control group for PGP. This means that pregnant women are often excluded from the evidence base and denied the right to informed choice regarding their own care. Despite this there is still far more published research than has been included in this review. This must be re-examined before publishing guidelines what will impact the wellbeing of women for at least the next 3 -5 years. Please review this evidence again before proceeding, with leaving manual therapy out of the NICE guidelines for the treatment of PGP. Pregnant individuals are essential patient populations, not just women who can wait. The evidence ton manual therapy for the treatment of PGP has not been fully represented. Please review the below list of studies on the topic. The inclusion criteria must be reassessed. 1. Outcomes of pregnant patients with low back pain undergoing chiropractic treatment: a prospective cohort study with short term, medium term and 1 year follow-up Cynthia K Peterson, Daniel Mühlemann & Barry Kim Humphreys *Chiropractic & Manual Therapies* volume 22, Article number: 15 (2014)	

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				2. Sick leave and healthcare utilisation in women reporting pregnancy related low back pain and/or pelvic girdle pain at 14 months postpartum. Cecilia Bergström, Margareta Persson & Ingrid Mogren *Chiropractic & Manual Therapies* 24, Article number: 7 (2016) 3. Spinal manipulative therapy for acute low-back pain. Sidney M Rubinstein, Caroline B Terwee, Willem JJ Assendelft, Michiel R de Boer, and Maurits W van Tulder Cochrane Database Syst Rev. 2012 Sep 12;2012(9):CD008880 4. Chiropractic Care for Adults With Pregnancy-Related Low Back, Pelvic Girdle Pain, or Combination Pain: A Systematic Review Carol Carol Ann Weis 1, Katherine Pohlman 2, Crystal Draper 3, Sophia daSilva-Oolup 3, Kent Stuber 4, Cheryl Hawk 5 J Manipulative Physiol Ther. 2020 Sep;43(7):714-731. 5. Idiopathic Pelvic Girdle Pain as it Relates to the Sacroiliac Joint Use of Manual Therapy for Posterior Pelvic Girdle Pain Derek Miles, PT, DPT , Mark Bishop, PT, PhD, PM&R Volume11, IssueS1 6. Osteopathic manipulative treatment for low back and pelvic girdle pain during and after pregnancy: A systematic review and metaanalysis Helge Franke, D.O. a , Jan-David Franke, B.Sc a , Sebastian Belz, M.Sc D.O. b , Gary Fryer, PhD., B.Sc(Osteopathy) c, d, *J Bodyw Mov Ther. 2017 Oct;21(4):752-762.	

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				The hundreds of manual therapists this organisation represents, has had experience of implementing treatment plans for women struggling with PGP with success. We would be willing to submit case studies and other permitted evidence of their experiences to the NICE. Please contact **Sharon Sackey, sharondc@belloost.com 07594500444.**	
Belloost LTD	Evidence review U	028	027-029	We are concerned that this recommendation may imply that there is no need for in person visits to the physiotherapist and virtual visits would suffice. Research shows that physical examination is of paramount importance in the diagnosis of pregnancy-related pelvic girdle pain to allow the appropriate treatment plan of hands-on care and appropriate exercises to be administered. On Page 27, lines 31-34 you state that there is an 'increased risk of experiencing adverse events' with unsupervised home exercises. Thus recommending a support belt and exercises over the phone with no in person assessment is in direct contraction to the statement highlighting the risks.	Thank you for this comment. The committee carefully considered the wording of this recommendation. The committee agree that the wording of the recommendation does not imply that there is no need for an in person visit, but allows the healthcare professional to make a judgement based on specific cases, and gives the option of a telephone consultation if they judge this is appropriate. They used the evidence in combination with the economic model to make a recommendation that was carefully balanced in terms of benefits and harms to women and NHS services.
Best Beginnings	Guideline	General	General	We recommend that the guidance includes resources such as 'Always Ask' designed to enable parents to make any health concerns they may have known to healthcare providers. This recommendation stems from MBRRACE findings on perinatal/maternal deaths.	Thank you for this comment. The committee fully agree that parents should be enabled to raise any concerns with the healthcare professionals. In the guideline this has been made explicit by recommending that at every appointment, the woman (and her partner) is

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					asked if they have any concerns they'd like to discuss. Furthermore, the recommendation makes it clear that antenatal care services/providers should provide a safe environment and opportunities for the woman to discuss anything on her mind. The resource you link to is not accredited by NICE so no reference has been made to it in the recommendations but NICE will add this to the 'Information to the public' tab on the guideline website. We will also pass this information to the NICE resource endorsement team. More information on endorsement can be found here: https://www.nice.org.uk/about/what-we-do/into-practice/endorsement.
Best Beginnings	Guideline	001	Covering page	We are concerned that the phrase 'simplicity of language' with regard to gender identity may appear to be reductionist for those parents who do not identify as 'women', especially when the guideline qualifies that in spite of acknowledging gender diversity the term 'women' will be used throughout. Rather, acknowledging at the start that this term includes women and/or gestational parents might be more inclusive. Further information about gender inclusive language for perinatal services has been published by Brighton and Sussex NHS trust.	Thank you for this comment which the NICE editorial team considered. The references text has been revised to reflect the feedback.
Best Beginnings	Guideline	017	010	We feel in this section, weight is given to the woman's/gestational parent's voice in terms of concerns surrounding the pregnancy. However, a	Thank you for this comment. The recommendation you are referring to has been revised to include the partner as well.

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				stronger emphasis on parents' rights to ask questions and have autonomy over their care would be helpful. It is important to make it clear that all women have the right decline treatment they do not want and have the right to choose where to give birth (Birthrights, *Consenting to Treatment, Choice of Place of Birth*), having been given evidence in a form that they can understand and with opportunities to discuss it to enable them to make an informed decision.	Furthermore, the committee has added a recommendation that when offering any type of care, the benefits, harms and implications should be discussed and women should be made aware that they have the right to decline. Other recommendations also cover that the content and delivery of information provision should be tailored to the woman's needs and preferences.
Best Beginnings	Guideline	044	015	We are happy to see that the guideline acknowledges the supplementing information provided face-to-face with online sources of information increases knowledge. We would like to refer to an evaluation of the Best Beginnings' Baby Buddy app. Bland C, Dalrymple KV, White SL, Moore A, Poston L, Flynn AC. Smartphone applications available to pregnant women in the United Kingdom: An assessment of nutritional information. Matern Child Nutr. 2020 Apr;16(2):e12918. doi: 10.1111/mcn.12918. Epub 2019 Dec 12. Summary of findings: This review identified 29 pregnancy-related apps available to UK women and assessed nutritional information in line with national recommendations. They found that:	Thank you for this comment. We will pass this information to our resource endorsement team. More information on endorsement can be found here: https://www.nice.org.uk/about/what-we-do/into-practice/endorsement.

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				• Several apps conveyed inappropriate information for pregnancy • There was a need for the integration of both evidence-based nutritional information during app development and for increased regulatory oversight to ensure that nutritional content is accurate before it is available for widespread use • Only two apps, one being Baby Buddy (and the other a commercial app with adverts), fulfilled all accountability criteria and contained no inaccurate information. • Nicola Crossland ∗, Gill Thomson, Victoria Hall Moran. Impact of parenting resources on breastfeeding, parenting confidence and relationships. Midwifery 81 (2020) 102591. - *Key conclusions:* While there were issues with the receipt and use of the resources, the resources were well received by women and professionals. While the resources did not appear to have influenced par- ents' confidence and self-efficacy, there may be a positive impact on mother–infant bonding. Further re- search is needed to understand whether more focussed integration of the resources into care pathways over a longer term can increase user engagement, and the impact of such on key parenting outcomes.	

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Birth Trauma Association	Guideline	General	General	One concern is that women with Braxton Hicks contractions or pain in the final trimester of pregnancy or women who are post dates seem not to be given the attention they need because they fall between the Intrapartum guideline and Antenatal guideline. We would request that the GDG ensure that women with these problems are properly covered by one or other guideline and are properly assessed because they seem to have a much higher than average rate of adverse outcomes (eg arriving at the labour ward with an intrapartum death).	Thank you for this comment. This was not a topic covered by the scope of this guideline but we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Birth Trauma Association	Guideline	010	008	'Ask about concerns...' It would be good to include a line about women who have previously had a traumatic birth. They need special support and early discussion of their mode and place of birth plans. Waiting until after week 28 can be harmful to women with severe anxiety about the birth.	Thank you for this comment. We have added previous trauma (which includes traumatic birth) as an example to the next bullet about providing a safe environment to discuss any issues.
Birth Trauma Association	Guideline	014	019	'Do not routinely offer ultrasound after 28 weeks.' Women who have suffered prior loss, antenatal complications or are suffering anxiety about their baby's position or position of the placenta should not go unheard. We would prefer rewording to 'Do not routinely offer ultrasound after 28 weeks but consider the views and individual circumstances of the woman.'	Thank you for this comment. There was no evidence that routine ultrasound after 28 weeks is beneficial. However, in general the guideline makes it clear that women's concerns should be listened and responded to.
Birth Trauma	Guideline	016	001	Instead of 'Offer cephalic version' please reword 'Explain the risks and benefits of cephalic version'. It is not being explained to women that a)	The recommendation has been revised to say that the benefits, harms and implications of all

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Association				ECV can be extremely painful b) they do not have to accept it c) it does not improve outcomes i.e. they are at exactly the same risk of complications as if they had a breech birth. d) ECV slightly increases risk of low APGAR score for the baby. For evidence, see: 1.https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1038-1 2.Effects of external cephalic version for breech presentation at or near term in high-resource settings: A systematic review of randomized and non-randomized studies Aase S Devold Katarina Johansen 3, Anne C Staff 1 3, Katariina H Laine 1 3, Ellen Blix 2, Inger Økland 4 5 3. High incidence of obstetric interventions after successful external cephalic version. BJOG.2002 Jun;109(6):627-31. Chan LY, Leung TY, Fok WY, Chan LW, Lau TK. 4. Intrapartum cesarean delivery after successful external cephalic version: a meta-analysis. Chan LY, Tang JL, Tsoi KF, Fok WY, Chan LW, Lau TK.	the options (external cephalic version, breech vaginal birth or elective caesarean birth) are discussed.
Birth Trauma Association	Guideline	016	011	Under Communication, we'd like to see a bullet point that states that listening is a key communication skill.	Thank you for this comment. The committee agrees and have added a recommendation about this to the beginning of this section.
Birth Trauma Association	Guideline	017	015	It would be good to see an additional bullet point 'women who have previously had a traumatic birth or stillbirth' as an example of women who may need additional support.	Thank you for this comment. This recommendation refers to a specific NICE guideline which covers particular groups of women who may need additional support. In

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					order to avoid further confusion, we have revised the wording in the recommendation and moved the recommendation to a more appropriate section in the guideline. Otherwise, any additional support based on medical, social or emotional reasons are covered by other recommendations earlier in the guideline.
Birth Trauma Association	Guideline	019	015	It would be good to see some consideration of consent here. It's not just about making women aware of the implications, benefits and risks of their birth preferences, it's about supporting them to use that information to make an informed decision about their labour, and respecting that decision as part of a shared decision-making pathway.	Thank you for this comment. The committee agrees and has added recommendations in the section on Communication - keys principles relating to informed decision making, right to decline and the importance of respecting the woman's choice.
Birth Trauma Association	Guideline	019	020	After 28 weeks, we'd like to see women given information about common birth complications including PROM instrumental delivery, tears, caesarean section, post dates. In the list of things that women should be made aware of for the postnatal period, 'postnatal self-care' seems inadequate in terms of giving women information about when to raise concerns about their physical wellbeing. The postnatal guidelines go over this in more detail, but a lot of this information should be shared antenatally - if women aren't told of health warning signs to look out for, then it is all too common for women to feel they shouldn't report concerns because 'it's normal to feel like this after	Thank you for this comment which the committee discussed. The committee agreed that the common complications in labour and birth are covered by the recommendation about discussing the implications, benefits and harms of the different options for birth. The committee also added common events in labour and birth (which would include common complications) as a topic for antenatal classes. The committee agreed not to be prescriptive or detailed about the discussions around postnatal selfcare but

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				birth'. So it would be good to have reference to pain and pain management, bleeding, fever, signs of infection etc, and crucially when and how to raise these concerns. Many women report that the 6-week baby check is when they plan to raise concerns about their own health, but their concerns are often sidelined at this point as the focus is on the baby.	agree that it is important to have discussions around postnatal selfcare with women during pregnancy.
Birth Trauma Association	Guideline	020	009	In antenatal classes, it would be good to make sure women are offered information about common birth complications.	Thank you for this comment. The committee agreed to add that "common events in labour and birth" would be covered, which would include common complications as well.
Bliss	Guideline	General	General	The guideline makes reference to common problems identified during pregnancy, such as pre-eclampsia, poor fetal growth and gestational diabetes, which increase the likelihood of preterm birth and/or a neonatal admission. While the guideline recognises the opportunities to escalate care to more specialist settings and highlights the increased risk of preterm birth at points, there are no recommendations for informing the woman and her partner about a neonatal admission. Bliss' response will highlight in specific recommendations where this could be included, but would urge the Committee to consider more broadly the inclusion of a recommendation specifically within the information and support section to highlight that where antenatal monitoring suggests the woman may be at increased risk of preterm birth or if it is identified that	Thank you for this comment which the committee discussed. The committee added a recommendation to make it clear that whenever an investigation, examination or a procedure is offered (e.g. risk assessment), the benefits, risks and implications should be discussed with the woman. This would include consideration for increased risk of preterm birth or neonatal admission related to some circumstances. The committee also added a recommendation about discussion around the chance of preterm birth in relation to unexplained vaginal bleeding.

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				her baby may need neonatal care that both herself and her partner are given information about what this will entail including: - Signposting to national and local organisations for support - Organising a tour of the neonatal unit where the baby is likely to be cared for - If the baby is likely to need intensive care or is at risk of being delivered extremely preterm, women should be involved in discussions about how this may impact her care (e.g. change of birth setting)	
Bliss	Guideline	General	General	In sections such as 'Taking the woman's history' where there is reference to ethnicity, please ensure that 'Black' and 'White' are capitalised. Throughout the Guideline currently only 'Asian' is capitalised.	Thank you for this comment. The NICE style is to only capitalise proper nouns, legislation, questionnaire titles, projects, campaigns and brands. The NICE style guide does not provide specific guidance on whether to capitalise ethnic groups, but it does provide examples about how to talk about where a person is from. The NICE style guide has been developed with input from Gov.uk's style guide (as well as other sources), but it does not follow Gov.uk's style guide to the letter because NICE often talks about people in a different context to the Government. In the case of family background and ethnicity, NICE follows the NHS style guide, specifically the examples on the inclusive

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					language page and the NHS glossary for racial literacy, in which 'black' and 'white' are not capitalised. Although none of these resources include an instruction saying 'do not capitalise', the NICE style guide follows their examples. NICE is constantly researching and redeveloping its style guide to take into account developments in language from various sources – the news, government reports, the NHS language matters, and academic papers – as well as people's views. NICE is including the stakeholder comment as part of this ongoing research, so it will directly feed into NICE's ongoing research on capitalisation and ethnicity.
Bliss	Guideline	008-009	021-019	It is welcome to see reference to the MBRRACE-UK reports on perinatal and maternal mortality referenced within this guideline. When discussing neonatal outcomes, Bliss would suggest referencing the figures for increased risk of neonatal death among Black and Asian Babies as well. For babies of Black and Black British Ethnicity mortality rates are described by MBRRACE-UK as ''exceptionally high'' and the report also states: '' whilst both stillbirth and neonatal mortality rates have seen a reduction over time there has been a small increase in the ratio of mortality rates for babies of Black or Black British ethnicity'' (MBRRACE-UK. 2020)	Thank you for this comment. After careful consideration, a decision was made to highlight the increased stillbirth rates in the antenatal care guideline and highlight the increased neonatal deaths in the postnatal care guideline (published in April 2021).

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Bliss	Guideline	020-021	010-005	Please see comment 10. Consider including information on what to expect if a baby is born needing additional care after birth during antenatal classes.	Thank you for this comment which the committee discussed. The topics listed are examples and it is not an exhaustive list. The committee wanted to avoid being to prescriptive so this has not been added.
Bliss	Guideline	014-015	021-007	Consider expanding this recommendation to include reference to providing women with information and support if her baby is at an increased risk of a neonatal admission if there have been concerns that baby is small for gestational age.	Thank you for this comment. The committee added a general recommendation that when anything unexpected is found in investigations or examinations, appropriate information provision and support should be ensured.
Bliss	Guideline	007	003-021	It is important to be aware that the COVID-19 pandemic continues to disrupt partner presence across the maternity pathway, including during antenatal care. Despite guidance from NHS England, some pregnant women are still unable to consistently have a partner with them during antenatal appointments or during scans as there has been variation in approach between different services. Pregnant women have reported the significant detrimental impact it has had on them and their partners if they receive difficult news during antenatal appointments. For some women this has meant finding out their baby has died or is likely to die before or after birth, or that their baby is likely to be born needing specialist care from the neonatal unit when they are born.	Thank you for this comment. The scope for this guideline update was developed in 2018, therefore, COVID-19 was not featured in it and evidence reviews and recommendations were largely developed before the pandemic. The impact of the COVID-19 pandemic on partner involvement in antenatal care was therefore not featured in the evidence review. However, the committee discussed that providing other opportunities for partners to attend, if in line with the woman's wishes, such as the use of virtual platforms for appointments could help with partner attendance and this was included in the recommendations. The committee however recognised that evidence on virtual/video consultations and appointments was not

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				The guideline committee should consider reviewing emerging evidence about the impact of COVID-19 on maternity settings and parent experience, and consider including a specific recommendation regarding maintaining partner presence at all antenatal appointments, if this is in line with the woman's wishes. Guidelines from NHS England are here: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0961-supporting-pregnant-women-using-maternity-services-during-the-coronavirus-pandemic-14-december-2020.pdf	reviewed for this guideline and that there are potential inequalities issues that could be associated with video appointments and this has been discussed in the 'Committee's discussion of the evidence' section in evidence report C.
Bliss	Guideline	008	004	Suggest amending this bullet point to read "her medical history and obstetric history, including whether she has previously experienced a miscarriage, stillbirth, neonatal death or neonatal admission and her family history"	Thank you for this comment. Asking about her obstetric history should cover these points. We have purposefully not added an exhaustive list of issues as part of medical, obstetric and family history as this list could potentially be very long and the guideline is not aiming to be a text book style checklist.
Bliss	Guideline	012	001-013	Consider including a recommendation to provide women with information and support if her baby is at an increased risk of a neonatal admission.	Thank you for this comment, we have added a recommendation about this, as suggested.

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Bliss	Guideline	012	014-023	Consider including a recommendation to provide women with information and support if her baby is at an increased risk of a neonatal admission.	Thank you for this comment, we have added a recommendation about this, as suggested.
Bliss	Guideline	013	001-022	Consider including a recommendation to provide women with information and support if her baby is at an increased risk of a neonatal admission.	Thank you for this comment, we have added a recommendation about this, as suggested.
Bliss	Guideline	019	004-012	Bliss welcomes the focus of this recommendation on providing information and support to women and their partners on how to bond with their newborn baby, and the importance of emotional attachment. If a baby is born needing neonatal care it is equally as important that parents are supported to provide hands on care to their baby. Not only does this support bonding and attachment, it also improves outcomes for babies and parents. For many families, a neonatal admission is not expected and many will not know what neonatal care is until their baby is admitted. Bliss hears frequently from parents who wish they had been better prepared for what would happen to their baby. Having these discussions during antenatal care and signposting to organisations like Bliss can help parents feel more prepared if their baby is born needing additional support after birth. Consider adding an additional bullet point to this recommendation to include ''if a neonatal admission after birth is anticipated, provide information on what to expect on a neonatal unit, arrange a tour of the	Thank you for this comment. Specialist care as such is outside the scope of this guideline, however, the committee has added a recommendation about providing appropriate information and support to those whose babies are considered to be at an increased risk of neonatal admission after birth.

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				neonatal unit and provide information on how to be actively involved in care following a neonatal admission.'' Research references to support the positive benefits of parental involvement in neonatal care: O'Brien et al (2018) Effectiveness of Family Integrated Care in neonatal intensive care units on infant and parent outcomes: a multicentre, multinational, cluster-randomised controlled trial, Lancet Child Adolesc Health, 2(4):245-254; Pineda et al (2017) Parent participation in the neonatal intensive care unit: Predictors and relationships to neurobehavior and developmental outcomes, Early Human Development, 117:32-38. Flacking et al (2012) Closeness and Separation in neonatal intensive care, Acta Paediatr, 101(10): 1032–1037	
Bliss	Guideline	030	010-014	Consider including a recommendation to provide women with information and support if her baby is at an increased risk of a neonatal admission.	Thank you for this comment. The committee agreed to include a recommendation about discussing the increased risk of preterm birth with women who have unexplained vaginal bleeding.
Breech Birth Network, CIC	Evidence Review L	010	012	The women and health care professionals in our network are concerned about the following statements: "Unexpected breech presentation in labour and mode of birth were prioritised as critical outcomes by the	Thank you for this comment. We have considered your suggestion and have amended the wording to reflect the different options available to women. The recommendation was

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				committee. This reflects that most women with a known breech presentation at term opt for either external cephalic version or elective caesarean section. This in turn demonstrates that women and/or clinicians are uncomfortable with the risks of aiming for vaginal breech birth and the associated risks such that unexpected breech presentation in labour would ideally be avoided." We recommend that NICE any statement about what 'most women' want or opt for, as such statements pressure all women to conform. At the very least, claims should only be made after a review of evidence about what women want, interpreted in light of the existing qualitative evidence about the difficulty women face when attempting to plan a VBB. We would also ask the committee to consider that such a statement in a national guideline is likely to become a self-fulfilling prophecy. When language varies between guidelines without justification, this leads to inconsistent counselling, confusion and disappointment for women and birthing people. Women and health care professionals in our network inform us that what women 'opt for' is heavily determined by the available options and does not necessarily reflect the choices that are important to them. In our PPI group, we have had to really consider our skills and obligations in responding to women who have experienced trauma, to support their full	also revised based on stakeholder feedback to reflect the different options women have.

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				participation with minimal distress. While a small number of women report trauma due to birth complications, baby loss and/or complications of CS, by far the greatest amount has to do with judgemental attitudes and/or resistance encountered when attempting to plan a vaginal breech birth. Even when women have been successful with their attempt, they remember this difficulty with great pain. Some women report balanced counselling and support from some clinicians, but then lose confidence as they encounter others who repeatedly try to 'talk them out of it' when they feel that VBB is right for them, or ask them to explain why they would take such a risk. The inconsistency is unsettling. It therefore further aggravates people's sense of lacking support and choice when a national guideline suggests that 'most women opt for ECV or CS.' This does not match the lived experience of many women who have wanted to opt for a VBB and further silences those who have experienced provider unwillingness to provide support for a vaginal breech birth. To say that 'most women are uncomfortable with the risks of attempting a VBB' also suggests that those who wish to plan a VBB are a small minority of risk-takers, and it implies the same of the professionals who support them. A significant minority of women are less comfortable with the risks of CS in this pregnancy and future pregnancies than they are with the risk of VBB. Others wish to avoid the risk of early term emergency CS, which is associated with ECV, regardless of the well-documented overall safety of the procedure.	

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				It is frustrating that the NICE evidence review process sticks to RCTs for the evidence but relies on the clinical experience of a small committee for interpreting it and determining the outcomes that matter most. Evidence about what women opt for when offered unbiased, evidence-based counselling indicates that between 35% (1) and 52% (2) of women would opt for a VBB. Even in an American context, where most women also have a CS, preference studies indicate most women would prefer a vaginal breech birth (3). This theoretical work is backed up by observational studies of what happens when a supportive model of care is introduced (4). In addition to the views of our PPI group (records available at: https://optibreech.uk/2019/04/29/ppi-proposal-development/), qualitative evidence is available that women face considerable difficulty if they wish to plan a vaginal breech birth (5–8), or if they are not keen to attempt an ECV (9,10). It is therefore important that the national guideline remain neutral in its language and not add to the difficulty women face when declining the 'offers' NICE guidance recommends. This is not at all to argue that the committee should not recommend that ECV be offered, but rather that great care should be taken to explicitly acknowledge the importance of supported individualised decision-making, in line the NICE Intrapartum Care and RCOG guidelines. Some women will decline ECV, and that is okay; some women will choose VBB, and that is okay; and some women will prefer a CS, and that is okay.	

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				We do not wish to argue that unexpected breech presentation in labour is not an outcome that matters to women and babies. Many women would prefer to consider their options and make the choice that is in line with their wishes and values prior to the start of labour; this is a treatment burden and an opportunity. Additionally, women who have experienced the professional panic that ensues in cases of undiagnosed breech presentation have found this traumatising, whether or not they and their baby are well afterwards (13). In our consultations, women expressed the wish that breech presentation and all three options associated with it be mentioned in antenatal classes so that it is not so shocking when revealed to the >1:25 women who experience breech presentation at term or are found to be breech in labour. While our group would agree that unexpected breech presentation in labour is important to consider, we take issue with the currently stated rationale for why.	
Breech Birth Network, CIC	Evidence Review L	010	016	Our group also contains clinicians who teach clinical skills and/or are conducting research about vaginal breech birth. We have had numerous reports from other clinicians, and our own experience indicates, that care providers frequently face hostility from other colleagues when supporting women who wish to 'opt for' a vaginal breech birth. Many colleagues are indeed not comfortable offering this choice, despite the RCOG and NICE Intrapartum Care guidelines (11). This leaves many clinicians with no choice	Thank you for this comment. We have considered your suggestion and have amended the wording to reflect the different options available to women. The recommendation was also revised based on stakeholder feedback to reflect the different options women have.

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				but to inform women that whether they can attempt a VBB or not will depend on the support available on the day. Unsurprisingly, this is not an attractive option for women. But a lack of training or confidence among professionals is not a burden that women should have to carry; it is a professional responsibility to provide a safe service. Clinicians in our network expressed concern that if statements like these remain in the guideline, and if the importance of informed choice is not made explicit, the guideline will effectively deprive women of the option of choosing a VBB because clinicians will perceive that it is 'against the NICE guideline.' Such language will also discourage clinicians from acquiring the necessary training and skill for VBB and would put undiagnosed emergency cases at risk due to lack of skills. Recently published research indicates that, even with a universal screening service and comprehensive ECV service in place, the overall incidence of breech presentation at birth did not change, and approximately 1:20 breech presentations were still discovered in labour unexpectedly (12). The current wording also appears to condone clinicians' discomfort with VBB as an indication for not supporting it as an option. We feel this needs to be challenged. If Mode of Birth is a critical outcome for women, which those in our network believe it is, it remains important that the choice of a VBB continue to be offered and that clinicians continue to develop VBB skills.	

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Breech Birth Network, CIC	Evidence Review L	011	026	It is worth noting that Magro's review of litigation costs for cerebral palsy claims indicates that breech presentation is over-represented, but that 5/6 cases were diagnosed late in labour, when the most experienced support was not in attendance (14). A single successful litigation claim alone could likely fund hand-held scans by midwives in the UK, and such costs were not included in Wastlund's economic model. It is likely that both women and providers would benefit from time to prepare for breech births, although women will only fully benefit if there is a care pathway available which offers them a full range of choices, including external cephalic version (ECV), vaginal breech birth (VBB) and caesarean section (CS). Again, we are not necessarily recommending the committee change its opinion on the current evidence base, but we feel the committee should be aware of this.	Thank you for bringing this to our attention. Medico-legal costs are not usually included in NICE economic evaluations in a quantitative way given the inherent difficulties in estimating such costs. Full consideration is given to this issue in a qualitative way for all recommendations in the guideline given the potential significant resource impact.
Breech Birth Network, CIC	Evidence Review L	011	038	We are concerned about the committee citing its clinical experience, rather than evidence about the rates of palpation diagnosis and/or rates of undiagnosed breech in labour, to interpret the evidence. Our group contains multiple midwives who have conducted multiple audits of detection rates, and the evidence does conform to our clinical experience.	Thank you for this comment. All recommendations are made using the best available evidence and the committee's expertise and opinion. The committee highlighted that the one economic study identified for routine scans concluded there was uncertainty around cost effectiveness. There was uncertainty around a number of key inputs of the model given it was based on one observational study with a high risk of bias. A number of these inputs also did not match the committees experience in addition

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					to the identified risks around the study estimates. Given the uncertainty around cost effectiveness, the clinical evidence and the potential for a large resource impact from a recommendation favouring routine scans the committee did not think it was appropriate to recommend such an approach. The committee were aware of a number of uncertainties and gaps in high quality evidence for this topic and did make a research recommendation for this topic.
Breech Birth Network, CIC	Evidence Review M	General	General	To prepare this feedback we: 1. Put out an invitation to contribute to collective feedback via the Breech Birth Network's blog, our FaceBook group, and the PPI group for the OptiBreech research project, which has overlapping interests and members. The invitation was also shared to members in the Breech Birth UK FaceBook group. 2. Hosted a public Zoom meeting on 13 February 2020 3. Collated the views of those attending, and those submitted via e-mail and/or the FaceBook page 4. Shared our proposed feedback with the groups and those who attended or commented 5. Incorporated comments into the feedback document and our published summary 6. Submitted the feedback according to the NICE pathway	Thank you for this comment and for collating this feedback. This evidence review included experimental evidence on interventions to manage breech presentation, and therefore qualitative data on the views and experiences of pregnant women were not identified, so the committee did not comment on this directly as such. However, the committee revised the recommendation based on stakeholder feedback that all options and their benefits, harms and implications should be discussed with the woman. The committee also added a general recommendation which states that women's decisions should be respected even if they differ from the views of the healthcare professionals.

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				We feel it is important to let some of these voices speak directly, so we have included summaries and quotes we have permission to share below. From our engagement meeting (using a pseudonymous initial only): "Guidelines should clearly state, if you (a hospital) don't have experience, then have a system of referral." (S, mother) "It is not acceptable for hospitals to say to a woman that they don't have experienced people. It is their imperative to have somebody or provide an alternative solution." (service user rep BB) Participants expressed concern that current guidelines would prevent women from making the decision to have a VBB. BJ (midwife) mentioned that a lot of women are now choosing home and water breech births. Mothers stressed the importance of feeling supported in their decision. E (mother) and S both had the eventual outcome of a CS, but E had a supportive midwife throughout the time, whereas S did not. Accordingly, both had very different experiences. E expressed that a lot of her confidence in her midwife came down to the training and experience of people attending the birth. N (midwife) expressed that VBB training needs to be mandatory. H (obstetrician) agreed. Both felt that the TBT is still at the back of HCW's minds. But it is important to focus on the optimal birth for the mother – "It is our duty as practitioners to support the woman."	

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				Many participants felt the attitude of HCWs is important, and that if guidelines are not clear about their duty to support maternal choice, this will not occur. The HCWs in the meeting stressed support from the Trust is crucial. N stressed the importance of a named midwife for breech care. H also agreed on importance of language and consistency, saying guidelines will allow doctors to have fact-based discussions with women and midwives, not opinion-based like now. S (mother) suggested that breech discussions and possible management should be a part of standard antenatal education for women. Information is crucial to prevent panic. Open discussions will also eliminate stigma surrounding breech. P (mother) expressed concern around not being able to access ECV after a caesarean, and felt that guidelines should include risks to mothers of having CS. She was aware that support and success were often dependent on the skill and experience of the individual practitioner and wondered why guidelines did not make more reference to this. She was also concerned about inconsistency between NICE guidance (37 weeks) and RCOG guidance (from 36 weeks for primips) and wondered if her care was inadequate because as a primip she was not offered ECV until 37+ weeks. Written statements sent to us:	

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				"Hi. I had a planned natural breech birth in Feb 2020 … I found out baby was breech around 28/30 weeks, I had lots of scans/consultations at the hospital where I felt like my only option was a section, I got presented with some scary statistics where I was putting my baby at risk if I wasn't to go with the hospitals plans. I also had a failed ECV where again we were told how dangerous a natural birth would be to the baby and that a section was what was best. I was devastated. I'd been receiving acupuncture due to pelvic girdle pain and had spoken to the midwife about breech birth, straight away she told me not to worry and section wasn't my only option. I was told to try moxibustion and lots of different exercises to try and get baby to move … but baby wasn't up for moving! The community midwife asked me to contact her when my ECV was over and let her know how we'd got on. She came over to see us and said she was happy to take over my care and was happy to support me with the natural delivery on the birth centre as I wanted. She and a matron attended the future hospital appointments with us to ensure we wasn't being put under pressure to have a section again. I received home visits as I neared the end of my pregnancy and was able to contact the midwife any time when I thought I was in labour or had any questions so she could meet us at the hospital when needed. We had a couple of failed starts, we later found out this was due to baby being in a back to back position so labour kept stopping. Eventually 6 days late my waters broke and baby came along very quickly! She ended up being born feet first, needing a couple of manoeuvres to turn her. Both myself and baby were fine and so grateful to have gotten the	

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				birth that we wanted, with lots of support from the midwife. I know without this midwife I'd have ended up having a section, feeling that that was my only option." "In my experience as an antenatal teacher and doula in [English city], where the local trust doesn't support vaginal breech birth, I see two categories of people: the ones who get given a narrative that vaginal breech birth is dangerous (by their medical caregivers) and do not question the narrative, and the ones who want a vaginal birth, who have read research and understand the risks aren't as big as we are made to believe, but do not feel safe having a vaginal birth as they know that there are no confident caregivers to support them (there are a handful of consultants who are confident supporting breech birth, however there are no guarantees that any of them will be present on the day). In my view the confidence has to filter through …." (doula) "This is both appalling and disappointing at the same time, instead of saying that clinicians aren't comfortable supporting breech birth they should work towards training clinicians to become comfortable instead of recommending against VBB." A Consultant Obstetrician "The reason women are uncomfortable with the idea of breech birth is because the HCPs are so uncomfortable and unskilled. The answer should be to improve HCP skill and comfort, NOT measure success by its	

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				avoidance. The measure of success should be increased levels of comfort and confidence." L, mother of a breech baby "I had a footling breech daughter 2 years ago. I was told that a vaginal delivery was too dangerous and I shouldn't even start labour. Attempted an ECV which failed so was booked in for csection at 39+2. I am now 34 weeks pregnant and baby is currently frank breech. My consultant is trying to push towards another csection but I am very keen on a vbac to hoping for a successful ECV or for baby to turn on its own. I am also considering a vaginal breech birth but am a bit nervous about it due to all the scaremongering around it." C, mother "This is just wonderful to read. As a mother of an undiagnosed breech baby who was given no choice but to have a section, this makes me feel so emotional. Women should be given evidence based information to allow them to make the best decision for them. With my second pregnancy, I had done so much research and had more information and was prepared to fight for a VBAC. It was so refreshing to hear the consultant midwife say "Well we'd just support you to have a vaginal breech birth!" She said it so casually and as if it were nothing, whereas the professionals four years previously had all given me that reproachful look when I asked about vaginally breech birth while I was in labour. I cried when that consultant midwife made it sound like a breech vaginally birth was so normal – this is what I had been striving for, as after all the research I had done, I knew this	

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				was the case. Thank you for fighting for us, for the parents who need this, changing the mindset of breech being alien is truly liberating. Choice is so important. Thank you x" – T, mother	
Breech Birth Network, CIC	Evidence Review M	029	007	Breech vaginal birth after unsuccessful ECV We are concerned that presenting a reduction in successful vaginal breech birth, especially after attempted ECV, as a critically important outcome, is disrespectful to the women who obviously 'opted for' a VBB. This item and the associated figure present what appears to be the only 'high quality evidence' for a 'clinically important difference' the committee considered. The committee concluded that the evidence 'favoured' ECV plus μ-receptor agonist over ECV plus placebo, on the basis that it significantly reduced breech vaginal birth after unsuccessful ECV. We would like the committee to consider the way in which such a conclusion reflects an inherent bias against vaginal breech birth. Such a presentation of data is disrespectful to the women in these studies who evidently 'opted for' a vaginal breech birth, and for whom achieving one was the positive outcome that they sought: a normal vaginal birth. Again, we would ask the committee to consider the qualitative evidence base that indicates a significant minority of women do not want the	Thank you for this comment. The committee discussed the importance of respecting the woman's wishes if she chooses to have a vaginal breech birth and have included a general recommendation about respecting the woman's choices even if they differ from the views of the healthcare professional. The evidence identified for review question M reported cephalic vaginal birth as a more preferable outcome of ECV than breech vaginal birth and so the analysis in evidence review M reflects the way the data has been reported in the evidence. The committee discussed that the way the evidence is presented should not mean that the woman's wishes for her birth preferences are overlooked. Therefore the committee revised the recommendation on management of breech presentation in line with your and other stakeholder comments and the updated NICE Caesarean Section guideline, to reflect the different management options available to women with breech presentation. The review question did not include a qualitative

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				eradication of vaginal breech birth, but better, more skilled and confident support for this option. We would ask the committee to consider how rating a reduction in vaginal breech birth as a critically important outcome must feel to women who have struggled to choose this option, which is supported as a reasonable choice in the current RCOG and NICE Intrapartum guidelines. We would ask the committee to consider that evidence indicates that, where women and professionals have different choices, they choose different options. For example, in one centre, following the recent introduction of a breech clinic and team, planned VBBs increased from 7.4% to 53.0%, while the effective vaginal breech delivery rate increased from 4.3% to 43.5% (4). This team started with a VBB rate similar to most UK hospitals and a similar level of experience. Where such a choice is offered within the UK, women may very well make similar choices. While this observational evidence is outside the scope of your evidence review, it should be sufficient to guide a reconsideration of your committee's statements about what women would prefer. A national guideline needs to acknowledge that the safety and availability of vaginal breech birth varies widely between hospitals, and informed choice of either ECV, VBB or CS needs to be supported according to context and individual values. This is not to say that we do not feel the evidence base warrants offering an ECV. Because of the extremely variable attitudes and experience levels	analysis on the views and experiences of women with a breech presentation and therefore no evidence was identified to inform this, and the committee have not commented on this.

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				related to VBB throughout the UK, in many settings, ECV remains the only reasonable option a person can make to reduce their chances of having a CS. Cephalic presentation may indeed be a critical outcome for women in a hospital that does not support VBB well; in another hospital, it may not be. We only ask that the committee be evidence-based and honest that this is more about what providers are comfortable with, and not about what women want.	
Breech Birth Network, CIC	Evidence Review M	034	036	The discussion states, "Existing evidence suggests that breech presentation in labour is associate with increased adverse outcomes for the fetus." (The implied comparator was cephalic presentation in labour following ECV.) We are concerned that this statement, unqualified, over-emphasises the potential risks. The evidence we are aware of indicates that: 1) ECV does not improve neonatal outcomes. This is evident in the current review and multiple Cochrane Reviews. 2) The difference between breech compared with cephalic labour is described in the RCOG guideline as 'relatively small (1/1000)'. This applies to cephalic labour in general rather than post-ECV. 3) Multiple studies have indicated that breech presentation at term is associated with a greater rate of congenital anomalies than cephalic presentation (15).	Thank you for this comment and thank you for sharing this data and the references. We have amended this statement within the discussion to better reflect the potential risks associated with breech presentation.

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				4) The available observational evidence indicates similar outcomes between cephalic presentation post-ECV and VBB. In a large UK cohort study, ECV was associated with a combined stillbirth and neonatal mortality rate of 1.9 per 1000 (16), including all subsequent modes of delivery: cephalic births, breech births and CS. A population-level cohort study in the Netherlands associated planned vaginal breech birth with a perinatal mortality rate of 1.6 per 1000, and 1.3 per 1000 when cases undiagnosed before labour were excluded (17). Also in the Netherlands during the same period, a large series reported a perinatal mortality rate of 1.73 per 1000 following ECV (18). These figures suggest near parity in neonatal outcomes between cephalic birth following ECV and breech birth and calls into question the premise that breech presentation in labour results in significantly worse neonatal outcomes in this population. A systematic review has identified that the perinatal mortality figures for breech births across several studies were less than reported for cephalic vaginal delivery during the same time period (19), and other authors have suggested that our expectations of the outcomes of breech labours are unreasonably high when they are compared to CS rather than vertex birth (20). In our group's experience, what matters to most but not all women is whether they will be able to have what they consider to be a normal vaginal birth with a good outcome for their baby. For those who prefer a	

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				vaginal birth, this means avoiding a CS or instrumental delivery. If their best chance of that is to have an ECV, they will have an ECV. If they have a decent chance of achieving a well-supported vaginal breech birth, many will choose to attempt one, with or without a prior attempt at ECV. The available evidence also indicates that instrumental delivery rates during a VBB are lower than during cephalic birth.	
Breech Birth Network, CIC	Evidence Review M	036	035	There is a published ECV cost-effectiveness study, which determined that it is only cost-effective if over 32% successful (21). Significant observational evidence indicates that success rates vary depending on the operator, exemplified by the 14% success rate reported by Wastlund (22) versus the 49% success rate reported by Melo (16) recently in the UK. Women in our network also wanted guidelines to acknowledge the wide variation in success rates attributable to the experience of the provider and to recommend research in this area, as well as information about local success rates being provided.	Thank you for this comment. Although there was no evidence identified for this topic in evidence review M, the committee discussed the variation in success rates of ECV can be attributable to the experience of the provider. Based on your and other stakeholder comments, the discussion section of evidence review M has been amended to include this point. Thank you for providing references to Melo 2019 and Wastlund 2019. The study Melo 2019 was excluded at the title and abstract stage of the systematic review process because it uses a cohort study design, which falls into the exclusion criteria for evidence review M and therefore was not included. The study Wastlund 2019 has been included in review L 'Identification of breech presentation' in the health economic analysis.
Breech Birth	Evidence Review M	119	Figure 29	As above.	Thank you for this comment. The committee discussed the importance of respecting the

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Network, CIC				Breech vaginal birth after unsuccessful ECV We are concerned that presenting a reduction in successful vaginal breech birth, especially after attempted ECV, as a critically important outcome, is disrespectful to the women who obviously 'opted for' a VBB. This item and the associated figure present what appears to be the only 'high quality evidence' for a 'clinically important difference' the committee considered. The committee concluded that the evidence 'favoured' ECV plus μ-receptor agonist over ECV plus placebo, on the basis that it significantly reduced breech vaginal birth after unsuccessful ECV. We would like the committee to consider the way in which such a conclusion reflects an inherent bias against vaginal breech birth. Such a presentation of data is disrespectful to the women in these studies who evidently 'opted for' a vaginal breech birth, and for whom achieving one was the positive outcome that they sought: a normal vaginal birth. Again, we would ask the committee to consider the qualitative evidence base that indicates a significant minority of women do not want the eradication of vaginal breech birth, but better, more skilled and confident support for this option. We would ask the committee to consider how rating a reduction in vaginal breech birth as a critically important outcome must feel to women who have struggled to choose this option, which is	woman's wishes if she chooses to have a vaginal breech birth and have included a general recommendation about respecting the woman's choices even if they differ from the views of the healthcare professional. The evidence identified for review question M reported cephalic vaginal birth as a more preferable outcome of ECV than breech vaginal birth and so the analysis in evidence review M reflects the way the data has been reported in the evidence. The committee discussed that the way the evidence is presented should not mean that the woman's wishes for her birth preferences are overlooked. Therefore the committee revised the recommendation on management of breech presentation in line with your and other stakeholder comments and the updated NICE Caesarean Section guideline, to reflect the different management options available to women with breech presentation. The review question did not include a qualitative analysis on the views and experiences of women with a breech presentation and therefore no evidence was identified to inform this, and the committee have not commented on this.

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				supported as a reasonable choice in the current RCOG and NICE Intrapartum guidelines. We would ask the committee to consider that evidence indicates that, where women and professionals have different choices, they choose different options. For example, in one centre, following the recent introduction of a breech clinic and team, planned VBBs increased from 7.4% to 53.0%, while the effective vaginal breech delivery rate increased from 4.3% to 43.5% (4). This team started with a VBB rate similar to most UK hospitals and a similar level of experience. Where such a choice is offered within the UK, women may very well make similar choices. While this observational evidence is outside the scope of your evidence review, it should be sufficient to guide a reconsideration of your committee's statements about what women would prefer. A national guideline needs to acknowledge that the safety and availability of vaginal breech birth varies widely between hospitals, and informed choice of either ECV, VBB or CS needs to be supported according to context and individual values. This is not to say that we do not feel the evidence base warrants offering an ECV. Because of the extremely variable attitudes and experience levels related to VBB throughout the UK, in many settings, ECV remains the only reasonable option a person can make to reduce their chances of having a CS. Cephalic presentation may indeed be a critical outcome for women in a hospital that does not support VBB well; in another hospital, it may not be.	

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				We only ask that the committee be evidence-based and honest that this is more about what providers are comfortable with, and not about what women want.	
Breech Birth Network, CIC	Guideline	015	General	The women and health care professionals in our network recommended that this guideline adopt language that is consistent with that used in the most recent guidelines, NICE Intrapartum Care for women with existing medical conditions or obstetric complications and their babies and RCOG Guideline on the Management of Breech Presentation. The NICE Intrapartum Care guideline acknowledges, "There is variation in practice regarding counselling … for women with a breech presentation following publication of the Term Breech Trial in 2000, which concluded that vaginal birth was associated with higher risks to the baby. The recommendation to offer women … a choice … will promote a more consistent approach and improved experience for women … guideline recommendations emphasis choice and informed decision making. The committee was aware that training may be needed to fully implement the recommendations supporting vaginal breech birth." (1.15.3) We recommend that any new guideline about breech management also acknowledge the wide variation in practice and emphasis choice and informed decision-making explicitly.	Thank you for this comment. The committee agreed to change the recommendation so that all the options and their benefits, risks and implications should be discussed. The committee also added a general recommendation that it should b ensured that when any investigation or procedure is offered, the risks, benefits and implications are discussed with the woman and she is aware that she has a right to decline.
Breech Birth Network, CIC	Guideline	015	020	The women and health care professionals in our network don't feel it is helpful to use the term 'normal' in this context, to refer to cephalic birth.	Thank you for this comment. The committee agrees. The recommendation was revised and this sentence was removed altogether.

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				The Committee will no doubt be aware of the general controversy surrounding use of the term 'normal' birth, following on from the Ockenden Report. This term is very loaded. It is very possible to have what women consider to be a 'normal' vaginal birth with a bottom-first baby, and not all women who have a head-first baby have a 'normal' birth. Women who have had a 'normal breech birth' consider themselves to have had a 'normal birth,' so consider this not to reflect their lived experience. We suggest this term is not appropriate for use in this context, as it reflects a medical viewpoint rather than that of women themselves.	
Breech Birth Network, CIC	References			1. Kok M, Gravendeel L, Opmeer BC, van der Post JAM, Mol BWJ. Expectant parents' preferences for mode of delivery and trade-offs of outcomes for breech presentation. Patient Educ Couns [Internet]. 2008 Aug;72(2):305–10. Available from: http://www.sciencedirect.com/science/article/pii/S0738399108002139 2. Abdessalami S, Rota H, Pereira GD, Roest J, Rosman AN. The influence of counseling on the mode of breech birth: A single-center observational prospective study in The Netherlands. Midwifery [Internet]. 2017 Dec 21 [cited 2017 Nov 14];55:96–102. Available from: http://www.ncbi.nlm.nih.gov/pubmed/28987933 3. Yee LM, Kaimal AJ, Houston KA, Wu E, Thiet M-P, Nakagawa S, et al. Mode of delivery preferences in a diverse population of pregnant	Thank you for the list of references. We have cross checked the references with our search strategy and inclusion/exclusion criteria. The quoted references do not match the review protocols so are not relevant for inclusion. Please see below for reasons for exclusion: 1. Kok M, Gravendeel L, Opmeer BC, van der Post JAM, Mol BWJ. Expectant parents' preferences for mode of delivery and trade-offs of outcomes for breech presentation. Patient Educ Couns [Internet]. 2008 Aug;72(2):305–10. Available from: http://www.sciencedirect.com/science/article/pii/S07383991080021392. Study not identified

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				women. Am J Obstet Gynecol [Internet]. 2015 Mar [cited 2014 Oct 24];212(3):377.e1-377.e24. Available from: http://www.sciencedirect.com/science/article/pii/S0002937814010849 4. Derisbourg S, Costa E, De Luca L, Amirgholami S, Bogne Kamdem V, Vercoutere A, et al. Impact of implementation of a breech clinic in a tertiary hospital. BMC Pregnancy Childbirth [Internet]. 2020 Jul 29 [cited 2020 Sep 6];20(1):435. Available from: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-03122-4 5. Petrovska K, Watts NP, Catling C, Bisits A, Homer CS. 'Stress, anger, fear and injustice': An international qualitative survey of women's experiences planning a vaginal breech birth. Midwifery [Internet]. 2017 Jan [cited 2016 Nov 22];44(0):41–7. Available from: http://linkinghub.elsevier.com/retrieve/pii/S0266613816302662 6. Homer, Watts, Petrovska, Sjostedt, Bisits. Women's experiences of planning a vaginal breech birth in Australia. BMC Pregnancy Childbirth [Internet]. 2015 Dec 11 [cited 2015 Apr 22];15(1):89. Available from: http://www.biomedcentral.com/1471-2393/15/89 7. Petrovska K, Watts N, Sheehan A, Bisits A, Homer C. How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences. Health Risk Soc [Internet]. 2017 Feb 17 [cited 2016 Nov 22];19(1–2):19–37.	as it does not match study design criteria for both review questions (qualitative study) 2. Abdessalami S, Rota H, Pereira GD, Roest J, Rosman AN. The influence of counseling on the mode of breech birth: A single-center observational prospective study in The Netherlands. Midwifery [Internet]. 2017 Dec 21 [cited 2017 Nov 14];55:96–102. Available from: http://www.ncbi.nlm.nih.gov/pubmed/28987933. Study not identified as it does not match study design criteria for both review questions (qualitative study) 3. Yee LM, Kaimal AJ, Houston KA, Wu E, Thiet M-P, Nakagawa S, et al. Mode of delivery preferences in a diverse population of pregnant women. Am J Obstet Gynecol [Internet]. 2015 Mar [cited 2014 Oct 24];212(3):377.e1-377.e24. Available from: http://www.sciencedirect.com/science/article/pii/S0002937814010849. Study not identified as it does not match study design criteria for both review questions (qualitative study) 4. Derisbourg S, Costa E, De Luca L, Amirgholami S, Bogne Kamdem V, Vercoutere A, et al. Impact of implementation of a breech clinic in a tertiary hospital. BMC Pregnancy Childbirth [Internet]. 2020 Jul 29 [cited 2020 Sep 6];20(1):435.

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				Available from: https://www.tandfonline.com/doi/full/10.1080/13698575.2016.1256378 8. Sloman R, Wanat M, Burns E, Smith L. Midwives' views, experiences and feelings of confidence surrounding vaginal breech birth: A qualitative study. Midwifery [Internet]. 2016 Oct [cited 2016 Aug 6];41:61–7. Available from: http://linkinghub.elsevier.com/retrieve/pii/S0266613816301322 9. Say R, Thomson R, Robson S, Exley C. A qualitative interview study exploring pregnant women's and health professionals' attitudes to external cephalic version. BMC Pregnancy Childbirth [Internet]. 2013/01/18. 2013;13(1):4. Available from: http://www.biomedcentral.com/1471-2393/13/4 10. Watts NP, Petrovska K, Bisits A, Catling C. This baby is not for turning: Women's experiences of attempted external cephalic version. BMC Pregnancy Childbirth [Internet]. 2016 Dec 26 [cited 2016 Sep 1];16(1):248. Available from: http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1038-1 11. NICE. Intrapartum care for women with existing medical conditions or obstetric complications and their babies(NG121). National Institute for Health and Care Excellence; 2019. 12. Salim I, Staines-Urias E, Mathewlynn S, Drukker L, Vatish M, Impey L. The impact of a routine late third trimester growth scan on the	Available from: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-03122-45. Study not identified as it does not match study design criteria for both review questions (Observational study) 5. Petrovska K, Watts NP, Catling C, Bisits A, Homer CS. 'Stress, anger, fear and injustice': An international qualitative survey of women's experiences planning a vaginal breech birth. Midwifery [Internet]. 2017 Jan [cited 2016 Nov 22];44(0):41–7. Available from: http://linkinghub.elsevier.com/retrieve/pii/S026661381631626626. Study not identified as it does not match study design criteria for both review questions (qualitative study) 6. Homer, Watts, Petrovska, Sjostedt, Bisits. Women's experiences of planning a vaginal breech birth in Australia. BMC Pregnancy Childbirth [Internet]. 2015 Dec 11 [cited 2015 Apr 22];15(1):89. Available from: http://www.biomedcentral.com/1471-2393/15/897. Study not identified as it does not match study design criteria for both review questions (qualitative study) 7. Petrovska K, Watts N, Sheehan A, Bisits A, Homer C. How do social discourses of risk

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				incidence, diagnosis, and management of breech presentation in Oxfordshire, UK: A cohort study. Myers JE, editor. PLOS Med [Internet]. 2021 Jan 15 [cited 2021 Jan 16];18(1):e1003503. Available from: https://dx.plos.org/10.1371/journal.pmed.1003503 13. Lightfoot K. Women's experiences of undiagnosed breech birth and the effects on future childbirth decisions and expectations [Internet]. University of the West of England; 2018. Available from: http://eprints.uwe.ac.uk/33278 14. Magro M. Five years of cerebral palsy claims: A thematic review of NHS Resolution data [Internet]. 2017 [cited 2019 Aug 24]. Available from: https://resolution.nhs.uk/resources/five-years-of-cerebral-palsy-claims/ 15. Macharey G, Gissler M, Toijonen A, Heinonen S, Seikku L. Congenital anomalies in breech presentation: a nationwide record linkage study. Congenit Anom (Kyoto) [Internet]. 2021 Feb 8 [cited 2021 Feb 12];cga.12411. Available from: https://onlinelibrary.wiley.com/doi/10.1111/cga.12411 16. Melo P, Georgiou EX, Hedditch A, Ellaway P, Impey L. External cephalic version at term: a cohort study of 18 years' experience. BJOG An Int J Obstet Gynaecol [Internet]. 2019 Mar 23 [cited 2018 Dec 29];126(4):493–9. Available from: http://doi.wiley.com/10.1111/1471-0528.15475 17. Vlemmix F, Bergenhenegouwen L, Schaaf JM, Ensing S, Rosman AN, Ravelli ACJ, et al. Term breech deliveries in the Netherlands: did the	impact on women's choices for vaginal breech birth? A qualitative study of women's experiences. Health Risk Soc [Internet]. 2017 Feb 17 [cited 2016 Nov 22];19(1–2):19–37. Available from: https://www.tandfonline.com/doi/full/10.1080/13698575.2016.12563788. Study not identified as it does not match study design criteria for both review questions (qualitative study) 8. Sloman R, Wanat M, Burns E, Smith L. Midwives' views, experiences and feelings of confidence surrounding vaginal breech birth: A qualitative study. Midwifery [Internet]. 2016 Oct [cited 2016 Aug 6];41:61–7. Available from: http://linkinghub.elsevier.com/retrieve/pii/S026666138163013229. Study not identified as it does not match study design criteria for both review questions (qualitative study) 9. Say R, Thomson R, Robson S, Exley C. A qualitative interview study exploring pregnant women's and health professionals' attitudes to external cephalic version. BMC Pregnancy Childbirth [Internet]. 2013/01/18. 2013;13(1):4. Available from: http://www.biomedcentral.com/1471-2393/13/410. Study not identified as it does

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				2010 Dec 21;10(1):3. Available from: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-3 22. Wastlund D, Moraitis AA, Dacey A, Sovio U, Wilson ECF, Smith GCS. Screening for breech presentation using universal late-pregnancy ultrasonography: A prospective cohort study and cost effectiveness analysis. Myers JE, editor. PLoS Med [Internet]. 2019 Apr 16 [cited 2019 May 5];16(4):e1002778. Available from: http://dx.plos.org/10.1371/journal.pmed.1002778	https://dx.plos.org/10.1371/journal.pmed.1003 50313. Study not identified as it does not match study design criteria for both review questions (observational study) 13. Lightfoot K. Women's experiences of undiagnosed breech birth and the effects on future childbirth decisions and expectations [Internet]. University of the West of England; 2018. Available from: http://eprints.uwe.ac.uk/3327814. Study not identified as it does not match study design criteria for both review questions (qualitative study) 14. Magro M. Five years of cerebral palsy claims: A thematic review of NHS Resolution data [Internet]. 2017 [cited 2019 Aug 24]. Available from: https://resolution.nhs.uk/resources/five-years-of-cerebral-palsy-claims/15. Study not identified as it does not match study design criteria for both review questions (qualitative study) 15. Macharey G, Gissler M, Toijonen A, Heinonen S, Seikku L. Congenital anomalies in breech presentation: a nationwide record linkage study. Congenit Anom (Kyoto) [Internet]. 2021 Feb 8 [cited 2021 Feb 12];cga.12411. Available from:

					https://onlinelibrary.wiley.com/doi/10.1111/cga.1241116. Study not identified as it does not match study design criteria for both review questions 16. Melo P, Georgiou EX, Hedditch A, Ellaway P, Impey L. External cephalic version at term: a cohort study of 18 years' experience. BJOG An Int J Obstet Gynaecol [Internet]. 2019 Mar 23 [cited 2018 Dec 29];126(4):493–9. Available from: http://doi.wiley.com/10.1111/1471-0528.1547517. Study not identified as it does not match study design criteria for both review questions (observational study) 17. Vlemmix F, Bergenhenegouwen L, Schaaf JM, Ensing S, Rosman AN, Ravelli ACJ, et al. Term breech deliveries in the Netherlands: did the increased cesarean rate affect neonatal outcome? A population-based cohort study. Acta Obstet Gynecol Scand [Internet]. 2014 Sep 11 [cited 2014 Aug 12];93(9):888–96. Available from: http://doi.wiley.com/10.1111/aogs.1244918. Study not identified as it does not match study design criteria for both review questions (observational study) 18. Beuckens A, Rijnders M, Verburgt-Doeleman G, Rijninks-van Driel G, Thorpe J, Hutton E. An observational study of the success and complications of 2546 external cephalic versions

					in low-risk pregnant women performed by trained midwives. BJOG An Int J Obstet Gynaecol [Internet]. 2016 Feb 2 [cited 2015 Feb 8];123(3):415–23. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25639281 19. Study not identified as it does not match study design criteria for both review questions (observational study) 19. Berhan Y, Haileamlak A. The risks of planned vaginal breech delivery versus planned Caesarean section for term breech birth: a meta-analysis including observational studies. BJOG An Int J Obstet Gynaecol [Internet]. 2016 Jul 29 [cited 2015 Aug 4];123(1):49–57. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26234485 20. Study not identified as it does not match study design criteria for both review questions (observational study) 20. Ulander V-M, Gissler M, Nuutila M, Ylikorkala O. Are health expectations of term breech infants unrealistically high? Acta Obstet Gynecol Scand [Internet]. 2004/02/06. 2004 Feb [cited 2014 Aug 15];83(2):180–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/14756737 21. Study not identified as it does not match study design criteria for both review questions

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					21. Tan JM, Macario A, Carvalho B, Druzin ML, El-Sayed YY. Cost-effectiveness of external cephalic version for term breech presentation. BMC Pregnancy Childbirth [Internet]. 2010/01/23. 2010 Dec 21;10(1):3. Available from: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-322. Identified but excluded from clinical data as HE analysis. This study was excluded from HE analysis as it took a societal perspective. 22. Wastlund D, Moraitis AA, Dacey A, Sovio U, Wilson ECF, Smith GCS. Screening for breech presentation using universal late-pregnancy ultrasonography: A prospective cohort study and cost effectiveness analysis. Myers JE, editor. PLoS Med [Internet]. 2019 Apr 16 [cited 2019 May 5];16(4):e1002778. Available from: http://dx.plos.org/10.1371/journal.pmed.1002778 This study has been included in review L 'Identification of breech presentation' as a part of the health economic analysis.
British Dietetic Association	Evidence review A	General	General	• From studies in this review it was highlighted that women would like more dietary information and advice and that they would like advice to be individually tailored. It was also noted that women wanted advice and support on weight management in pregnancy.	Thank you for this comment. There was some qualitative evidence (N=2 studies) suggesting women wanted more information on diet and nutrition from their midwives. However, the effectiveness of accessing a dietitian during

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				• Although it is recommended that women are given advice on nutrition and diet including vitamin D at the booking appointment, there is no mention of the involvement of dietitians in the provision of this advice. We would advise that women who have concerns or questions about diet in pregnancy should have access to a dietitian who can answer their questions and provide advice which is tailored to their individual situation. This may be especially relevant where a woman is identified as having a restricted diet or specialised diet for medical or cultural reasons or who may be experiencing marked taste changes due to the pregnancy. Other NICE guidelines advice that women who have a BMI >=30 should be offered a referral to a dietitian, but concerns about weight management may not be limited to this group. Dietitians would be able to support women with eating a healthy diet while maintaining appropriate weight gain during pregnancy.	antenatal care was not investigated in this guideline and therefore we cannot include this in the recommendations. This issue may be more relevant for other NICE guidelines such as weight management before, during and after pregnancy, which is currently being updated. We have signposted to this NICE guideline and other NICE guidelines for further information about diet and nutrition.
British Dietetic Association	Evidence review G	General	General	• We note that women who are identified as having a BMI <=18.5 may be at risk of malnutrition (NICE guidance on Nutrition Screening) and consideration should be made of a referral to a dietitian. In a recent Public Health England report, it was noted that 4.5% of pregnant women were identified as being underweight. • Consideration should be also be given to using a validated screening tool such as 'MUST' to identify other pregnant women who may be	Thank you for this comment. Evidence on this area was not reviewed so the committee has not made recommendations about regular weight monitoring during pregnancy. This area might be more relevant to consider under other NICE guidelines such as Weight management before, during or after pregnancy, or Maternal and child nutrition. These guidelines are currently being updated and we would encourage you to register as a stakeholder and take part in the scope

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				at risk of malnutrition (see page 5 point 15.3 https://www.bapen.org.uk/pdfs/must/must_exec_sum.pdf) We recommend that where pregnant women are identified as being at risk of malnutrition then it would be clinically appropriate to monitor their weight each time they attend an antenatal appointment to check that they have appropriate weight gain.	consultation: https://www.nice.org.uk/guidance/indevelopment/gid-ng10191 (please click "Register as a stakeholder").
British Dietetic Association	Evidence review R	216-218	General	• This list of research recommendations is heavily pharmaceutical focused. Previous systematic reviews on the topic of hyperemesis gravidarum and nausea and vomiting of pregnancy have highlighted the lack of lack with regard to dietary/nutritional interventions. (Boelig et al., 2016; O'Donnell et al., 2016). • We recommend that these are low-cost research interventions that are likely to be more acceptable to pregnant women should be considered for future research. • As above please consider the core outcome set for hyperemesis gravidarum research (Jansen et al. 2020) and the James Lind Alliance Priority Setting Partnership for outcomes that are relevant to patients, clinicians and researchers; several of which are nutrition focused.	Thank you for this comment. The evidence included in this review included women experiencing nausea and vomiting, ranging from mild and moderate to hyperemesis gravidarum, as stated in the review protocol. The committee discussed that nausea and vomiting in pregnancy is a continuum with most cases presenting as mild to moderate and some as more severe. At the extreme severe end of the spectrum is hyperemesis gravidarum, which is a rare and significant condition with potentially serious consequences. The focus of this review was on interventions to treat nausea and vomiting in pregnant women and the committee considered the comprehensive management of hyperemesis gravidarum to be outside the scope of this guideline, which covers routine antenatal care. Therefore, the committee agreed that a research recommendation on dietary and nutritional interventions was not in the scope of this

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					guideline. The guideline committee discussed that corticosteroids are used for severe nausea and vomiting in pregnancy in current practice but little is known about the effectiveness, cost-effectiveness and long-term safety on the unborn child of corticosteroids during pregnancy and therefore made a research recommendation based on this.
British Dietetic Association	Evidence review R	007	General	• Outcomes: although "Women's experience and satisfaction of care during or at end of pregnancy" is listed as an important outcome, it is unlikely that experiences will be accurately communicated/disseminated in the format of an RCT study design. Qualitative studies would have been useful to include for this outcome. • Similarly, other outcomes such as maternal unintentional weight loss have not been included. Please consider the core outcome set for hyperemesis gravidarum research (Jansen et al. 2020) and the James Lind Alliance Priority Setting Partnership for outcomes that are relevant to patients, clinicians and researchers.	Thank you for this comment. We agree that women's satisfaction of care could be captured through qualitative research, however, because we had to be selective in the review questions in order to keep the scope feasible, the scope did not include a qualitative question on women's experiences of care related to nausea and vomiting in pregnancy and instead we tried to capture this via a quantitative review. The evidence included in this review included women experiencing nausea and vomiting in pregnancy, ranging from mild and moderate to hyperemesis gravidarum as stated in the review protocol. The committee discussed that nausea and vomiting in pregnancy is a continuum with most cases presenting as mild to moderate and some as more severe. At the extreme severe end of the spectrum is hyperemesis gravidarum, which is a rare and significant condition with potentially

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					serious consequences. The focus of this review was on interventions to treat nausea and vomiting in pregnancy and the committee considered the comprehensive management of hyperemesis gravidarum to be outside the scope of this guideline, which covers routine antenatal care. Therefore, the committee agreed that outcomes such as maternal unintentional weight loss were not included as it was not in the scope of this guideline.
British Dietetic Association	Guideline	022-026	008-016	Section on "nausea and vomiting". We are concerned this section is short and does not adequately distinguish between how to manage mild-moderate and more severe presentations. Please consider including the following pointers: • Consider severity of symptoms using the Pregnancy Unique Quantification of Emesis (PUQE) score, a quick simple tool as recommended in the RCOG guidelines (page 6). • Women who present to a healthcare setting with nausea and vomiting/hyperemesis gravidarum should have their weight monitored on each occasion and compared with usual/most recent weight in order to monitor their rate of unwanted weight change. Weight loss of 5% should be noted as a concern, as should persisting inability to eat and drink (RCOG guidelines). • Offer supportive care and signposting to suitable charities/groups (e.g. Pregnancy Sickness Support Charity).	Thank you for this comment which the committee considered at length. Firstly, assessing the severity of nausea and vomiting in pregnancy was not in the scope of this guideline so this has not been addressed. Regarding management of nausea and vomiting in pregnancy, the committee revisited the evidence the draft recommendations in light of your and other stakeholders' comments. The committee agreed that the review question was not aiming to cover comprehensive management of hyperemesis gravidarum including interventions for malnutrition, although the evidence review included women with hyperemesis gravidarum as well. Most of the evidence on the more severe end of nausea and vomiting in pregnancy would actually not necessarily be considered

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				Table 1 Advantages and disadvantages of different pharmacological treatments: • Consider also (especially in severe cases) the risks and disadvantages of non- treatment of persistent moderate-severe pregnancy sickness (including unintentional weight loss and malnutrition) which may outweigh the small risks and potential side effects of pharmacological approaches). Research by Fiaschi et al, 2019 suggests that most women presenting to hospital with NVP/HG do not have any antiemetics prescribed, thus highlighting potential cost savings of better and more timely prescribing and recognition of weight loss, malnutrition and dehydration. Better and earlier recognition of negative consequences of pregnancy nausea and vomiting will have the biggest impact on practice by reducing hospital admissions.	hyperemesis gravidarum which is a very significant condition. The guideline generally does not address the management of severe conditions and the committee concluded that this is also the case for hyperemesis gravidarum. Therefore, the committee decided to revise the wording in the recommendations and the evidence report so that instead of referring to 'hyperemesis gravidarum', the guideline now refers to 'moderate to severe nausea and vomiting in pregnancy'. The committee also added a recommendation that when the nausea and vomiting is so severe that it cannot be managed with treatments available from the primary/outpatient care (this would include women with hyperemesis gravidarum), inpatient care should considered.
British Dietetic Association	Guideline	028	001-004	We are concerned this section is short and does not adequately address some of the nutritional consequences of more severe presentations. Please consider including the following pointers: • Women at increased risk of malnutrition may be helped by referral to a dietitian for dietary advice and nutrition support as noted in the RCOG guideline no 69, page 4.	Thank you for this comment which the committee considered at length. Firstly, assessing the severity of nausea and vomiting in pregnancy was not in the scope of this guideline so this has not been addressed. Regarding management of nausea and vomiting in pregnancy, the committee revisited the

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				• They should also be questioned about the number of recent days during which they have been unable to eat/retain food eaten and fluids (Page 7 Table 1 in RCOG guidelines). • Consideration should be given to using a validated screening tool such as MUST and referring those with a MUST score >=2 to a dietitian for nutrition support (see page 5 point 15.3 https://www.bapen.org.uk/pdfs/must/must_exec_sum.pdf). Some women with severe nausea and vomiting/hyperemesis gravidarum will be at risk of electrolyte changes and refeeding syndrome and they may require a short-term prescription of thiamine (page 18 RCOG guideline).	evidence and the draft recommendations in light of your and other stakeholders' comments. The committee agreed that the review question was not aiming to cover comprehensive management of hyperemesis gravidarum including interventions for malnutrition, although the evidence review included women with hyperemesis gravidarum as well. Most of the evidence on the more severe end of nausea and vomiting in pregnancy would actually not necessarily be considered hyperemesis gravidarum which is a very significant condition. The guideline generally does not address the management of severe conditions and the committee concluded that this is also the case for hyperemesis gravidarum. Therefore, the committee decided to revise the wording in the recommendations and the evidence report so that instead of referring to 'hyperemesis gravidarum', the guideline now refers to 'moderate to severe nausea and vomiting in pregnancy'. The committee also added a recommendation that when the nausea and vomiting is so severe that it cannot be managed

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					with treatments available from the primary/outpatient care (this would include women with hyperemesis gravidarum), inpatient care should considered.
British Medical Acupuncture Society	Evidence reviews underpinning recommendation 1.4.12	General	General	It seems clear that the approach to assessing the evidence for acupuncture is systematically different from that used in assessing evidence of more conventional therapies. Overall, the evidence in favour of acupuncture seems more convincing than that for the lumbopelvic belt, yet the latter is recommended and the former is not. Cost-effectiveness data from Nicolian 2019 appears to have been ignored entirely, and it is favourable to an acupuncture intervention by midwives	Thank you for this comment. Nicolian 2019 was identified by the search strategy and excluded as it did not present a quality of life based outcome measure. Full inclusion and exclusion criteria are available in the protocol. This study was incorrectly referenced as the conference abstract version in the list of excluded economic studies presented in the health economics supplement; the correct reference has now been included. The committee revisited the evidence on acupuncture based on this comment, but reached the same conclusion. We have updated the 'Committee's discussion of the evidence' section in evidence report U to better reflect the Committee's decision making.
British Medical Acupuncture Society	Evidence reviews underpinning recommendation 1.4.12	057-060	Table 4	Nicolian 2019 was a primary cost-effectiveness study that included measurement of productivity outcomes in the form of presenteeism and absenteeism. You have listed this trial as an effectiveness trial (page 58) and not included the primary outcomes of the paper, which were positive.	Thank you for this comment. This study was not included in the economic evidence review as it did not report a quality of life based outcome measure but was included in the clinical

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					evidence review where the following outcomes were extracted in line with the review protocol: •Pain intensity during pregnancy •Pelvic-related functional disability/functional status during pregnancy •Adverse effects during pregnancy •Admission at birth to the neonatal unit. Only outcomes listed in the review protocol are extracted regardless of whether they are primary or secondary outcomes in the relevant study. Days off work/sick leave was an outcome specified in the review protocol but absenteeism was not presented in a disaggregated form from cost in the study and therefore such outcomes were not included in the clinical evidence review. Except in a few circumstances NICE guidelines on clinical interventions only consider costs to the NHS and personal social services so such costs of absenteeism and presenteeism, where costs are borne by the individual, employer or other government departments, were not in the review protocol and were not formally considered by the committee.
British Medical	Evidence reviews	028	039	You suggest without data that there are not enough trained practitioners to perform acupuncture, almost all physiotherapy departments in NHS	Thank you for this comment. We have revised the wording in the evidence review to say "there

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Acupuncture Society	underpinning recommendation 1.4.12			hospitals have at least 1 physiotherapist trained in either dry needling or Western medical acupuncture. The Acupuncture Association of Chartered physiotherapists have over 5000 members, which is approximately 1 in every 10 physiotherapists in the UK. Many midwives are now being trained in the application of acupuncture for pain relief during labour. These techniques could also be applied to PGP in the antenatal period. The BMAS has supported a charity that educates midwives in the NHS, and has trained hundreds of NHS staff at very low cost over recent years.	may not be enough trained practitioners", this is based on the committee's knowledge and experience. Given your comment, the evidence for acupuncture was revisited by the committee but they came to the same conclusion that the evidence is not strong enough to warrant a recommendation on acupuncture for pelvic girdle pain and decided not to make changes to the recommendations.
British Medical Acupuncture Society	Evidence reviews underpinning recommendation 1.4.12	0050	Table 4	Kordi 2013 is rated low risk of bias with the following comment: Deviations from intended interventions: Low risk (participants and providers were not blinded, it is difficult to blind them) This is inconsistent with the high risk attributed to Elden 2005/2008b on page 40 Table 4: Deviations from intended interventions: High risk (participants and providers were not blinded)	Thank you for this comment and pointing out our error. We have addressed this inconsistency in the rating of bias, and have amended the rating for Kordi 2013, and other relevant studies. The committee have discussed the changes and agreed that the change in the rating does not change their conclusion and no changes were made to the recommendations.
British Medical Acupuncture Society	Evidence reviews underpinning recommendation 1.4.12	067	Table 5 001-002	Elden 2005/2008b is downgraded for imprecision based on small sample size. This is inconsistent with no downgrading of the smaller trial Kordi 2013 in row 1 of Table 12 page 80.	Thank you for this comment. When the data was reported with medians and interquartile ranges, as in Elden 2005/2008b, the imprecision of the effect estimate could not be assessed as per standard methods, and therefore the subjective ratings using sample size cut-offs were considered instead. Kordi 2013 reported data as a mean difference and therefore imprecision was

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					assessed as per standard methods. Please refer to Supplement 1 Methods for more information.
British Medical Ultrasound Society	Evidence Review L	011	043	We are reassured to see that NICE notes there is not enough evidence to support routine scans at 36w for breech presentation.	Thank you for this comment.
British Medical Ultrasound Society	Evidence Review O	General	General	We are concerned that no reference has been made as to when it is, or is not, appropriate to use Doppler ultrasound when monitoring fetal growth. Consequently, there is no advice on which vessels should be evaluated e.g. uterine artery, umbilical artery, MCA, ductus venosus etc. There is no advice on QA and image section, which will influence the reliability of EFW. No recommendations for future research have been made.	Thank you for this comment. The review question focused on whether routine ultrasound in pregnant women from 28 weeks is effective. The topics of when Doppler ultrasound is/isn't appropriate to use or advise on quality assurance and image section were not areas that were included in the scope of this guideline and evidence on it was not reviewed so the committee has not commented on it.
British Medical Ultrasound Society	Evidence Review Q	General	General	We are concerned that no reference has been made as to when it is, or is not, appropriate to use Doppler ultrasound when monitoring fetal growth. Consequently, there is no advice on which vessels should be evaluated e.g. uterine artery, umbilical artery, MCA, ductus venosus etc. There is no advice on QA and image section, which will influence the reliability of EFW. No recommendations for future research have been made.	Thank you for this comment. The review question focused on whether routine ultrasound in pregnant women from 28 weeks is effective. The topics of when Doppler ultrasound is/isn't appropriate to use or advise on quality assurance and image section were not areas that were included in the scope of this guideline and evidence on it was not reviewed so the committee has not commented on it.
British Medical	Guideline	General	General	It seems little has changed for routine care of pregnant women but, arguably, opportunities to improve and standardise practice have been	Thank you for this comment. The evidence that was reviewed did not suggest that Doppler

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Ultrasound Society				missed e.g. use of Doppler ultrasound. Furthermore, from evidence acquired so far, advocating the use of virtual platforms during scanning will likely have a detrimental effect on stakeholders.	ultrasound should be used in routine practice for scans so the recommendations do not comment on this. Evidence on the benefits and harms of virtual appointments was not reviewed for this guideline update for which the scope was developed in 2019. Of course since then, virtual appointments have become much more common and there will likely be evidence on its benefits and harms. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
British Medical Ultrasound Society	Guideline	037	017	We are concerned that encouraging partners to use virtual platforms will be interpreted by parents as endorsing the filming of antenatal ultrasound scans. Filming may breach GDPR and create safe-guarding issues for vulnerable women if recordings are posted on public forums. Filming may also impact on staff concentration, staff training, incidence of repeat scans, incidence of tertiary referrals and attempted litigation against Trusts at a time when there is an acute shortage of sonographers able to perform these scans.	Thank you for this comment. We understand the concern around filming during a scan, however, this issue is something to be managed through local arrangements.
British Medical Ultrasound Society	Guideline	042	028	We are reassured to see that NICE recognises more than one risk assessment tool for suspected small fetuses (SGA RCOG guideline as well as the NHS SBLCBV2)	Thank you for this comment.

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British Medical Ultrasound Society	Guideline	043	016	We are reassured to see that NICE notes there is no evidence to support routine 3rd trimester growth scanning and that, as a consequence, some trusts may be able to make cost savings.	Thank you for this comment.
British Pregnancy Advisory Service	Guideline	007	001	We welcome the support for continuity of carer. Evidence from our WRISK project, which explored antenatal care and risk communication during pregnancy, with more than 7000 women, found those who had an established relationship were better able to establish a trusting relationship conducive to more acceptable and person-centred antenatal care. Overall we welcome an approach within the guidance that is not overly proscriptive as regards the content of antenatal appointments: in our research there was a significant disconnect between the information women wanted (birth choices, medication use – particularly as regards concerns about coming off/reducing medicines, mental health and infant feeding) with what information was received, with a heavy emphasis on smoking and drinking and repeated questions on this which were found unhelpful by the many women who did not smoke or drink. Emphasis on the questions and concerns raised by women themselves is key.	Thank you for this comment and the support for this recommendation.
British Pregnancy	Guideline	019	020	Given that one in 16 primiparous women suffer severe perineal trauma this should be addressed antenatally, including a discussion about what measures may reduce the risk and the evidence-base thereof. Lack of	Thank you for this comment. The committee considered this but agreed that the risk of perineal trauma is covered by the

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Advisory Service				preparedness for the severity of perineal injury and its lifelong consequences has been raised by many women's pregnancy advocacy groups and appears as an issue within our own research as part of our WRISK project.	recommendation on discussing the woman's birth preferences, including discussion on the implications, benefits and harms of the different options. The committee also agreed to add common events in labour and birth (which would include common complications) to the recommendation on what to cover in antenatal classes. Furthermore, the guideline recommends discussing postnatal selfcare. The NICE guideline on postnatal care (published April 2021) covers perineal health in more detail.
British Pregnancy Advisory Service	Guideline	050	020-021	Non-pharmacological treatments are widely known and tried by pregnant women and women whose symptoms are mild enough to be helped by non-pharmacological treatment do not generally seek help from a healthcare professional. Women whose symptoms warrant seeking help should be reassured that pharmacological options exist and that being pregnant does not exclude the use of pharmacology.	Thank you for this comment. The guideline committee discussed this and revised the recommendations accordingly, including adding a recommendation about recognising that by the time women seek help to nausea and vomiting in pregnancy many have already tried various self-help methods, and that different pharmacological options are discussed with women seeking pharmacological interventions for their nausea and vomiting.
British Pregnancy	Guideline	050	019	It is important to note that mild pregnancy sickness is an expected part of pregnancy which women anticipate and often embrace as part of the	Thank you for this comment. The guideline committee have revised the recommendations to account for this.

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Advisory Service				pregnancy experience, most women tolerate quite severe symptoms and attempt various self help techniques before seeking medical help. Therefore when women feel symptoms are severe enough to seek medical opinion it is important to take them seriously and ask what self help has been tried before suggesting further non-pharmacological options or reassuring her that it is normal.	
British Pregnancy Advisory Service	Guideline	051	019-022	It is also important to discuss with women the risks of untreated (or undertreated) hyperemesis gravidarum and malnutrition for both her and the baby. There is plenty of evidence of the immediate and long term consequences for the offspring from first-trimester exposure to malnutrition. Additionally there is plenty of evidence of the biopsychosocial consequences for the mother. These risks, rather than the background risk of congenital malformations, should be discussed when deciding whether to take medication and which one.	Thank you for this comment. The text you're referring to has been revised but the point that we were trying to make is a more general comment around women's concern about taking medication during pregnancy. Based on the feedback from stakeholders the committee revisited the evidence and the draft recommendations for nausea and vomiting in pregnancy. The committee agreed that the review question was not aiming to cover comprehensive management of hyperemesis gravidarum but rather treatment for nausea and vomiting in pregnant women. Furthermore, most of the evidence on the more severe end of nausea and vomiting in pregnancy would actually not necessarily be considered hyperemesis gravidarum which is a very significant condition. The guideline generally does not address the

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					management of severe conditions and the committee concluded that this is also the case for hyperemesis gravidarum. Therefore, the committee decided not to include anything specific about information provision for women with hyperemesis gravidarum although your point is valid.
British Pregnancy Advisory Service	Guideline	051	022-024	While there may be some low quality evidence that ginger may help mild-moderate NVP, suggesting this can delay treatment of hyperemesis gravidarum, which poses significant harm for a significant number of women. Furthermore, the RCTs used to evidence this suggest that ginger does not cause harm however, evidence these studies are heavily biased towards ginger and do not assess the very real harm caused in the professional-patient relationship caused by suggesting ginger at the point of seeking medical help. For ginger to be suggested by a healthcare professional when seeking help for symptoms erodes trust and confidence as well as causing emotion harm and increased feelings of isolation. Women who present for termination of pregnancy due to severe pregnancy sickness have frequently been recommended ginger in place of pharmacological treatments.	Thank you for this comment. The guideline committee recommends trying ginger for the treatment of mild to moderate nausea and vomiting for those women who prefer a non-pharmacological option. The committee did not recommend ginger for more severe cases of nausea and vomiting during pregnancy. The evidence identified in this review on ginger did not show any evidence of harm on women with mild to moderate nausea and vomiting in pregnancy. The recommendations have been revised in line with other stakeholder comments, to account for those pregnant women who try various self-help approaches before seeking medical advice, and only present before a medical professional when it is serious. Thank you for providing this reference, which did not appear in our search strategy as it does not match the review protocol's inclusion criteria or the study design requirements for inclusion, and

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					therefore the committee did not comment on this.
British Pregnancy Advisory Service	Guideline	051	028-029	Acupressure is not effective for this condition. You state is page 50 line 24 that no other non-pharmacological treatments are effective so this recommendation is contradictory and confusing. Like with ginger, such suggestions can lead to delays of treatment and increased social-emotional harm among sufferers as well as an erosion of the patient-clinician trust.	Thank you for this comment. There was moderate quality evidence from two studies that showed the effectiveness of acupressure plus standard care over sham acupressure plus standard care in women with severe nausea and vomiting. Based on the evidence the committee made this recommendation. The text you are referring to has now been removed based on the revisions to the recommendations. We appreciate it caused confusion.
British Pregnancy Advisory Service	Guideline	052	011-013	"those prescribing medicines may need to spend more time discussing the options with the woman" – this would be a welcome change indeed if the discussion were to incorporate balanced discussion regarding the very real and serious risks of severe NVP and HG to both mum and baby and lack of curative treatment. Women would be helped massively if they were supported to understand that sometime medication in pregnancy is necessary and that they shouldn't feel guilty for requiring it. They should also feel reassured by the lack of evidence of any harm by these medications. We may not know which the most effective is by RCT data but there is substantial data that they are not causing harm, particularly when weighed against the harm of untreated HG and malnutrition.	Thank you for this comment. The guideline committee recommended having a discussion with the woman about the advantages and disadvantages of different antiemetics including taking into account her preferences and previous experiences, which supports informed and shared decision making. The evidence review looked at the harms of the medicines in terms of fetal or neonatal mortality, SGA and preterm birth. For other potential side-effects or risks, the committee signposted to the British National

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					Formulary (BNF) information and the summaries of product characteristics (SPCs).
British Pregnancy Advisory Service	Guideline	052	005-006	It is important to recognise that no evidence is not the same as 'it doesn't work'. You mention research in the area of corticosteroids but it is very little and of poor quality which significant heterogeneity. For example, none of the research where steroids were used assessed their efficacy in combination with antiemetics rather than in solo, or even documented where they were given in combination or alone – This is vitally important and current clinical practice thinking is that the steroids provide a boosting effect on the other antiemetics. Additionally, where a woman feels the alternative to further treatment, such as with steroids, is to terminate an otherwise wanted pregnancy then the benefits of trying them outweighs the harm of not. You refer to "well known harms" of corticosteroids but are not explicit. Please provide clarity of these well known harms, particularly to the fetus and in the context of the harms of undertreated HG where termination is highly likely. Corticosteroids are used in pregnancy for a vast range of other conditions where the potential benefits are considered to outweigh these "known harms", please provide context in relation to this specific condition.	Thank you for this comment. We agree that no evidence does not mean it doesn't work, however, with no evidence to support its use and knowledge of adverse effects of corticosteroids, the guideline committee made no recommendation on the use of corticosteroids. There was no evidence identified on the effectiveness of corticosteroids in conjunction with antiemetics and so the committee could not comment on this. The evidence tables in Evidence review R gives details of which corticosteroids were given and what the comparator was in each of the 5 RCTs identified. The committee discussed that corticosteroids have well-known harms as documented in the BNF but that they are still used in the management of severe cases of nausea and vomiting. As a result of the current limited evidence and their knowledge about the use of corticosteroids, the committee made a

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					research recommendation to inform future practice and guidance.
Caesarean Birth	Guideline	General	General	Thank you for this opportunity to comment.	Thank you for providing comments on the draft guideline.
Caesarean Birth	Guideline	005	001-002	Re: ensure that women have the information they need to make decisions and to give consent in line with General Medical Council (GMC) guidance and the 2015 Montgomery ruling. Page 4, line 16 of Caesarean Birth NICE guideline draft reads: "Discuss mode of birth with pregnant women early in their pregnancy." Given the Montgomery ruling, can NICE also include this statement in this guideline too? I remain concerned that many women are not made aware of their birth plan choices outside *place* of birth options. Improvements have definitely been made in the last decade, though not consistently throughout the NHS. For decades, the biggest difference between women being offered (even a discussion about) planned caesarean birth, and those who were not, was private versus public maternity care, with wealth and education often determining greater choice. Therefore, I am very mindful of social determinants of health and health inequalities in the NHS in the context of caesarean birth choice, and believe it is important that NICE ensures mode of birth choices are made clear in this guideline (even briefly), in addition to its more detailed caesarean birth guideline.	Thank you for this comment. The antenatal care guideline aligns with the recommendation in the Caesarean birth guideline and recommends that discussion around the woman's birth preferences should start before 28 weeks' gestation, the wording of the recommendation was revised to be clear that the implications, benefits and risks of the different options should be discussed. The exact timing of when the discussion start will depends on the individual needs and preferences and the committee has tried to find a balance of giving guidance but not being too prescriptive.

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Caesarean Birth	Guideline	006	0012-015	Re: a midwife or doctor Suggest: a midwife or obstetrician (as described/referred to in the NICE caesarean birth guideline)	Thank you for this comment. The committee agreed to say 'doctor' because in some areas and cases a GP might carry out an antenatal care appointment.
Caesarean Birth	Guideline	006	003-004	Re: risk factors including those that can potentially be reduced, for example, smoking Suggest including BMI/maternal weight here too.	Thank you for this comment. The committee agreed not to be too prescriptive in the recommendation, however, wanted to emphasise factors that could be addressed before booking appointment, perhaps most importantly smoking. Furthermore, the committee agreed to add that the early pregnancy information provided at the time of referral to antenatal care should include information on for example healthy eating.
Caesarean Birth	Guideline	006	017	Re: 1.1.8 Offer additional or longer antenatal appointments if needed, depending on the woman's medical, social and emotional needs. Please include reference to the NICE caesarean birth guideline here too, alongside the other 5 guidelines.	Thank you for this comment. Planned caesarean birth in itself is not necessarily a reason to provide additional or longer appointments and the NICE guideline caesarean birth does not comment on this either. The need for additional or longer appointments in the case of planned caesarean birth depends on the individual circumstances and reasons for planned caesarean birth. No changes were made.
Caesarean Birth	Guideline	008	004	Re: At the first antenatal (booking) appointment, ask the woman about: Suggest adding to list: her birth preferences	Thank you for this comment. The committee did not want to be prescriptive about when exactly to have the discussion about birth preferences

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					but recommended that the discussion should start before 28 weeks at the latest and the discussion should include discussing the benefits, risks and implications of the options. The booking appointment includes a lot of content in terms of assessments, history taking, information provision and discussions so it might not be the best timing to start the discussion on birth preferences. However, the guideline recommends that the timing, content and delivery of discussion should be tailored according to the woman's needs and preferences so there is flexibility.
Caesarean Birth	Guideline	009	020	Re: smoking referral Is there an equivalent for help and support with maintaining a healthy diet and physical activity during pregnancy?	Thank you for this comment. There isn't anything that is equivalent, however, the committee has added that early pregnancy information provided at the point of referral to antenatal care should include information on for example healthy eating.
Caesarean Birth	Guideline	014	001	Re: Monitoring fetal growth and wellbeing Page 49 (lines 28-29) reads: "The committee knew from their experience that providing practical advice about risk reduction is extremely important for pregnant women."	Thank you for this comment. The committee added a point about infections that may have an impact on the baby including group B strep to

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				I was surprised to note the absence of Group B Streptococcus (GBS) in this updated guideline, as there has been increased communication about the issue and calls to action from patient groups in the years since 2008: Group B Streptococcus is the UK's most common cause of life-threatening infection in newborn babies, and of meningitis in babies under age 3 months. https://gbss.org.uk/ Provide tests for Group B Strep to prevent any more avoidable deaths of newborn babies (758,516 signed) https://www.change.org/p/nhs-provide-tests-for-group-b-strep-to-prevent-any-more-avoidable-deaths-of-newborn-babies I understand that this test is not available on the NHS, but in the interests of the statement on page 49, could NICE include it in this guideline as something women should be made aware of at least, and then they can make a decision about whether to have the test privately? Again, one of my concerns is the inequality that lack of information (for all women) can lead to.	the recommendation about information to be discussed at booking appointment.
Caesarean Birth	Guideline	015	015-016	Re: If breech presentation is suspected on abdominal palpation, perform an ultrasound scan to confirm it. Could NICE also consider asking women about their own birth, and whether they were breech, in addition to relying on abdominal palpation. There has been some research on breech hereditary, for example:	Thank you for this comment which the committee discussed but did not consider this necessary. The 'diagnosis' of breech presentation is not impacted by the knowledge of family history of breech.

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				Maternal and paternal contribution to intergenerational recurrence of breech delivery: population based cohort study (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2323052/ Recurrence of breech presentation in consecutive pregnancies (2010) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2883072/	
Caesarean Birth	Guideline	015	019-020	Re: explain to women that turning the baby from a breech to a head down position makes a normal, head-first vaginal birth more likely and Suggest: If this is explained to women, then for balance, so should the research on planned caesarean birth outcomes for breech. Could NICE (as a minimum) consider including a link to the NICE caesarean birth guideline here?	Thank you for this comment. This section was revised and this sentence was removed.
Caesarean Birth	Guideline	016	001	Re: offer external cephalic version (for breech presentation) Suggest adding: and offer planned caesarean birth If this is not explicitly stated, it may not be routinely offered in all settings.	Thank you for this comment. The recommendation has been revised to say that the benefits, harms and implications of all the options (external cephalic version, breech vaginal birth or elective caesarean birth) are discussed.
Caesarean Birth	Guideline	016	010	Re: Communication with women This is an example of where the line in comment #1, above ("Discuss mode of birth with pregnant women early in their pregnancy.") could be included.	Thank you for this comment. The section on 'information about antenatal care' covers what information (and approximately when) should be discussed.
Caesarean Birth	Guideline	019	005	Re: emotional and relationship changes during the pregnancy Suggest adding: **physical**, emotional...etc.	Thank you for this comment. The committee have added 'physical' to the recommendation.

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Caesarean Birth	Guideline	021	014	Re: Peer support Did NICE consider referring to social media here too?	Thank you for this comment. The committee agreed not to specify particular types of peer support, although acknowledged that a lot of peer support may happen online or via social media.
Caesarean Birth	Guideline	022	003-004	Re: to maintain this position while sleeping It is not clear what "this position" is in this sentence. Should it read "avoid this position" (referring to sleeping on their back)?	Thank you for this comment, we have slightly amended the wording so hopefully it's clearer now, the recommendation is avoid supine position, not to sleep in a particular position.
Caesarean Birth	Guideline	031	005	Re: Continuity of carer Can NICE please specifically include 'obstetrician' in this section? It refers to a named midwife, a midwifery team, a healthcare team and a health visitor team, yet continuity of obstetrician carer is also of value to many women.	Thank you for this comment. Midwives are mentioned because of the reference to the Better Births, however, we mention that this could apply to any healthcare professional. This of course may include the obstetrician as well. This was not an area that was covered by the evidence reviews so the committee did not make any detailed recommendations around this.
Caesarean Birth	Guideline	033	005-007	Re: Identification of breech presentation - What is the clinical and cost effectiveness of routine ultrasound from 36+0 weeks compared with selective ultrasound in identifying breech presentation? Excellent inclusion.	Thank you.
Caesarean Birth	Guideline	036	004-006	Re: Better Births…recommends continuity of carer by 1 midwife who is part of a small team of midwives based in the community	Thank you for this comment. Midwives are mentioned because of the reference to the Better Births, however, we mention that this

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				Unfortunately, Better Births did not include recommendations for obstetrician continuity of carer, but it is very important that NICE does.	could apply to any healthcare professional. This of course may include the obstetrician as well. This was not an area that was covered by the evidence reviews so the committee did not make any detailed recommendations around this.
Caesarean Birth	Guideline	036	001-002	Re: There was good evidence that women value having the same midwife throughout their antenatal care Did NICE find any similar evidence related to having the same obstetrician throughout their antenatal care?	Thank you for this comment. There was no evidence identified that related to what women thought about having the same obstetrician throughout their antenatal care.
Caesarean Birth	Guideline	042	022	Re: Monitoring fetal growth and wellbeing This comments refers to a number of related sections: Page 18 (10): Examinations and investigations Page 22 (5-6): Explain to the woman that there may be a link between sleeping on her back and stillbirth in late pregnancy (after 28 weeks). Page 32 (7): Recommendations for research (e.g. Models of antenatal care) Page 43 (23-24): The committee were aware that cases of stillbirth have been linked to reduced fetal movements. Page 49 (28-29): The committee knew from their experience that providing practical advice about risk reduction is extremely important for pregnant women. In the context of late-term stillbirth risk, did NICE consider referring to/including mention of foetal hiccups, strong jerky movements (as opposed to reduced foetal movements), cord knots and/or cord entanglement here too? Was research such as (or similar to) any of the	Thank you for this comment. Foetal hiccups, strong jerky movements, cord knots and/or cord entanglement were not covered by the evidence reviews for this guideline and thus no comments have been made. The committee noted that in the studies that were relevant for the review question comparing routine ultrasound scan to selected ultrasound scan, no evidence was found on the impact of routine ultrasound scan on maternal anxiety and this was something that the committee thought would be valuable to know more about. However, none of the references listed fit the inclusion criteria for the review on routine ultrasound after 28 weeks in pregnancy and thus have not been included.

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				examples below reviewed and not included, or were these issues not considered for inclusion from the outset? Maternal Perception of Fetal Activity and Late Stillbirth Risk: Findings from the Auckland Stillbirth Study (2011) https://pubmed.ncbi.nlm.nih.gov/22112331/ Umbilical cord accidents (2012) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3428685/ Stillbirth is associated with perceived alterations in fetal activity – findings from an international case control study (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5683455/ Alterations in maternally perceived fetal movement and their association with late stillbirth: findings from the Midland and North of England stillbirth case-control study (2017) https://pubmed.ncbi.nlm.nih.gov/29982198/ The research above has relevance to comment #19, and it may be that this is what NICE is considering when it says, "The committee were in favour of research on this in the future" in the context of "ultrasound scans in late pregnancy". Clarification on this would be much appreciated.	
Caesarean Birth	Guideline	043	009-020	Re: When a baby is suspected to be large for gestational age, ultrasound scans could be used to assess the size of the baby and the volume of amniotic fluid. Small-for-gestational-age babies are at an increased risk of perinatal mortality and morbidity; Large-for-gestational-age babies are also at an increased risk of perinatal mortality and morbidity. Could this be reworded to include both?	Thank you for this comment. The committee agreed that being small for gestational age is a bigger concern in terms of mortality and morbidity than large for gestational age, especially if the baby has been consistency large

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				Re: The committee were aware that many women may request routine ultrasound scans in late pregnancy but available evidence showed no benefit from routine ultrasound in late pregnancy (from 28 weeks) for uncomplicated singleton pregnancies. However, the absence of effect found in the evidence does not definitely mean there is no effect. There was also no evidence on maternal anxiety in relation to routine ultrasound scanning. The committee were in favour of research on this in the future; Excellent inclusion.	for gestational age rather than a sudden change in the growth trajectory. The committee acknowledged the potential adverse outcomes related to large for gestational age, for example risk of shoulder dystocia, and these discussions by the committee have been documented in the evidence reviews.
Caesarean Birth	Guideline	043	028-029	Re: including more caesarean sections Please change to: more emergency caesarean births	Thank you for this comment. This is for all caesarean births (emergency + elective). Whilst emergency and elective were reported separately in the relevant study neither were statistically significant when considered alone. The text here is to state what the relevant study found and not to either highlight this as a positive or negative outcome.
Caesarean Birth	Guideline	044	002	Re: fewer caesarean births Please change to: fewer emergency caesarean births (unless this included all caesarean births?) It is important that reporting this Swedish study is not interpreted as NICE suggesting 'fewer caesarean births' is a quality outcome measure.	Thank you for this comment. This includes all caesarean births. We have referred to reductions here to report the results of the relevant study. We do not think it implies fewer caesarean births are either a positive or negative outcome.
Caesarean Birth	Guideline	045	003-007	Re: External cephalic version is standard practice for managing breech presentation in uncomplicated singleton pregnancies at or after 36+0 weeks, and is supported by the evidence. The committee did not recommend a change to current practice and agreed that healthcare	Thank you for this comment. The recommendations has been revised to say that the benefits, harms and implications of all the

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				professionals should discuss this with women to aid decision making. This relates to comment #9 above. ECV is only one option for women with breech presentation; another is to plan a caesarean birth. Importantly, the latter is also supported by the evidence. If current practice is to discuss and offer ECV in absence of discussing and offering planned caesarean birth, given that both options have risks and benefits, this is not in line with the 2015 Montgomery ruling.	options (external cephalic version, breech vaginal birth or elective caesarean birth) are discussed.
Caesarean Birth	Guideline	046	023-025	Re: Considering the amount of new information at the beginning of antenatal care, discussions around practical aspects related to labour, childbirth and postnatal care are more appropriate later on in the third trimester closer to the birth. My organisation disagrees with this in the context of the practicality of planning a caesarean birth; too many women still communicate stress related to being told no decision about planning a caesarean birth can be confirmed at the beginning of their antenatal care. There are actually women who want this decision confirmed before they even become pregnant. This is their main priority. Could NICE consider rewording this please, given that this guideline is for all women, and not just those who want to plan a vaginal birth, or are undecided, or whose situation may change during their pregnancy.	Thank you for this comment. The guideline recommends that discussion around the woman's birth preferences (including place of birth, mode of birth etc.) would be started before 28 weeks and the exact timing would depend on the individual preferences and circumstances of the woman, for some women this might be early in pregnancy, for some a bit later but always before 28 weeks. These discussions will of course include some practical aspects, however, many other practical aspects were considered most relevant closer to birth, however, the guideline aims for an individualised approach based on the woman's needs and preferences.
Caesarean Birth	Guideline	047	012	Re: The evidence showed that women want information on their options for giving birth. Could NICE specifically include 'place and mode' of birth here please (e.g. "their options for where and how to give birth")?	Thank you for this comment. The evidence review did not identify the place and mode of birth specifically as issues in this case, no change has been made.

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Caesarean Birth	Guideline	056	014-019	Re: Antenatal service delivery and provision of care have changed over time and this guideline updates and replaces the version of the NICE guideline on antenatal care (first published in 2008). This guideline covers routine antenatal care for all women. However, it does not cover specialised care for women with underlying medical conditions or obstetric complications (once diagnosed) but refers to other NICE guidelines. This paragraph illustrates my organisation's continued concern that the NICE guideline on caesarean birth (one of the "other" guidelines referred to here) might only be considered "specialised care" for "conditions" or "complications" outside 'normal' (e.g. pg.15) antenatal care in some settings or with some groups of women. While the decision remains to keep guidance on caesarean birth separate, it is important that NICE makes every effort to ensure that caesarean birth is firmly embedded in routine antenatal care discussions, starting with this guideline.	Thank you for this comment. We have revised the wording of the recommendation on discussion about birth preferences that it is clear that the implications, benefits and harms of the difference options are covered, and a reference is then made to the caesarean section guideline.
CMV Action	Evidence Review	010	001-002-003	CMV is missing from this list, despite being more common and affecting more babies than parvovirus and chickenpox	Thank you for this comment. This has been amended as suggested.
CMV Action	Guideline	General	General	Since the Antenatal guideline excluded infectious diseases in pregnancy from the scope (and the NICE quality standard on infection prevention and control does not include anything relevant to CMV and pregnant women), we believe consideration should be given to developing a guideline specifically on infectious diseases in pregnancy.	Thank you for this comment and for your suggestion for an additional NICE guideline on infectious diseases in pregnancy. The process for identifying and prioritising NICE guidelines is as follows: A topic selection oversight group at NICE considers topics for guideline development

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					taking a number of factors into account, as set out in the NICE Guidelines Manual. NICE then discusses topics identified in this way with NHS England, the Department of Health and Social Care, and Public Health England, and a prioritised list is agreed by these 3 bodies. Topics are then formally referred to NICE. A Cross-Agency Prioritisation Group was established in 2020 and held its first meetings in 2021. The group is working to finalise new principles to determine how topic referrals and guidelines identified for update within our existing portfolio can be scheduled, based on their relative priority and value to the health and social care system, taking into account the emergence and availability of new evidence.
Don't Screen Us Out	Evidence Review A	014	027	'Fetal disorder' 'pregnancy risks' this isn't standard wording and should say 'fetal anomaly' and 'chance' instead of 'risk' in line with Public Health standards.	Thank you for this comment. We have amended the language in line with your suggestion.
Don't Screen Us Out	Evidence Review A	014	029	'This meant that some older pregnant women sometimes found it difficult to remain positive.' This is not surprising considering the language that professionals often employ, such as 'risk' and 'disorder', terms which are anxiety-inducing. Language needs to be less anxiety-inducing. There should be something in the guidance about this issue and how professionals should be mindful of the sensitivities of pregnant women. The DSUK 2019	Thank you for this comment. The guideline emphasises the importance of respectful, sensitive and considerate discussions and information provision, tailored according to the individual needs and preferences of the woman. The committee have also added a recommendation about the importance of

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				"Sharing the News" report could be useful here https://www.downsyndromeuk.co.uk/flipbook.html	listening to women and responding to their needs and preferences.
Don't Screen Us Out	Evidence Review A	015	014	'the majority of pregnant women considered midwives the designated caregivers for health education, and considered them reliable sources of important information.' With this in mind, the Guidance should recommend that midwives undergo mandatory and CPD training about the conditions screened for in pregnancy and the lived-experience. This would be in line with recommendation from Nuffield Council of Bioethics in their 2017 report on NIPT: 'High quality education and training must be compulsory for all health and social care professionals involved in NHS prenatal screening.' https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing There needs to be mention in the guidance under review as to plans for development of this much needed pathway as NIPT is rolled out on an evaluative basis and the work is informed by Nuffield's work in the area of antenatal screening.	Thank you for this comment. Training of healthcare professionals is generally outside the remit of NICE although guidelines do occasionally comment on the expertise needed to deliver care or a specific intervention. Therefore, this was not a topic that was included in the scope of this guideline.
Don't Screen Us Out	Evidence Review A	022	Table 3 1,1,1.1	'all antenatal screening, including screening for haemoglobinopathies, the anomaly scan and screening for Down's syndrome, as well as risks and benefits of the screening tests' should also make reference to information about the screened-for conditions, in order to obtain informed consent which NICE regard as important. As referenced further down in the table.	Thank you for this comment. The text that is being referred to is a part of the review protocol that refers to wording in the previous Antenatal care guideline, which will be replaced by this update of the guideline. The committee have included in the recommendations that information about the screening programmes should be provided to enable informed decision making.

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Don't Screen Us Out	Evidence Review A	051	Table 5	The issue about women finding it difficult to remain positive, should be one of the Themes of Table 5 which could refer to: Down's syndrome Scotland 2017 Health Survey "Listen to Me, I have a Voice" which discusses information and support issues that women encountered during pregnancy and at birth https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf DSUK 2019 " Sharing the News" report https://www.downsyndromeuk.co.uk/flipbook.html This theme could also consider the research commissioned by PHS carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." This study found a lack of knowledge among pregnant women about screened-for conditions such as T13, T18 and T21 http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Thank you for providing the references of potentially relevant studies, which we have cross checked with our search strategy and inclusion/exclusion criteria. The quoted references do not match the inclusion criteria in the review protocols so have not been included in the review. Please see below for reasons for exclusion: https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf- this reference would not be flagged in this review as the scope of the guideline did not include a qualitative question about experiences of healthcare staff. https://www.downsyndromeuk.co.uk/flipbook.html- this reference would not be flagged in this review as the scope of the guideline did not include a question about the experiences of women who have a baby with Down's syndrome http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. This reference does not match the inclusion criteria

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					of the evidence reviews in this guideline and therefore cannot be included.
Don't Screen Us Out	Evidence Review B	General	General	This Evidence Review could also be informed by and include the research commissioned by PHS carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic. Furthermore, the quoted reference does not match the inclusion criteria in this particular review protocol so it was not included.
Don't Screen Us Out	Evidence Review B	General	General	'Severe fetal morbidity' isn't a commonly used phrase, this should be replaced with more meaningful terminology which may produce more useful evidence. 'Increased risk of abnormalities' should read 'increased chance of anomalies' in line with PHE standards. Other uses of 'abnormalities' in the doc should be reviewed	Thank you for this comment. The use of the words 'severe fetal morbidity' is present in the pre-defined review protocol and has therefore not been amended afterwards, however, it should be noted that the literature search and the subsequent evidence review was not bound by this particular terminology alone. The use of the words 'increased risk of abnormalities' and

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					other instances of the use 'abnormalities' have been changed to anomalies where appropriate, but not in evidence tables as reported in studies included in the review.
Don't Screen Us Out	Evidence Review C	General	General	This Evidence Review could also be informed by and include the research commissioned by PHS carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic. Furthermore, the quoted reference does not match the inclusion criteria in this particular review protocol so it was not included. Please see below for reason for exclusion: http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-

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					research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. This reference does not match the inclusion criteria of the evidence reviews in this guideline and therefore cannot be included.
Don't Screen Us Out	Evidence Review C	General	General	Review needed of the use of 'normal' and 'risk' in some places in the Evidence Review.	Thank you for this comment. The language has been revised according to your suggestion, where appropriate. The use of the word 'risk' is present in evidence tables as reported in studies included in the review.
Don't Screen Us Out	Evidence Review F	General	General	This Evidence Review could also be informed by and include the research commissioned by PHS carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic. Furthermore, the research you suggest is of a qualitative study

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					design which does not meet our criteria as set out in the protocol for this review so it was not included in the review.
Don't Screen Us Out	Evidence Review F	General	General	A recommendation made by Nuffield Council of Bioethics in their 2017 report on NIPT would have some bearing on the AN appointment for women on a new planned pattern of care continuing pregnancy after a positive test result for T13, T18 or T21: 'the National Institute for Health and Care Excellence (NICE) should produce clinical pathway guidance on the continuation of pregnancy after diagnosis of fetal anomaly.' https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing This should be a consideration of the Review which should reference the pathway.	Thank you for this comment. This guideline covers routine antenatal care for all women however, specialist care is outside the scope of this guideline. Therefore, we are unable to include information on a clinical pathway or the continuation of pregnancy after diagnosis of fetal anomaly. However, the committee added a recommendation which states that if there are any unexpected findings from examinations or investigations, referral should be offered according to local pathways and appropriate information and support should be provided.
Don't Screen Us Out	Evidence Review G	General	General	This Evidence Review should include a requirement for information about screened-for conditions to allow for informed consent in screening which is regarded as important to NICE.	Thank you for this comment. We have revised the recommendation on offering screening programmes to include this important point about providing information and discussion to allow for an informed decision making. We have also added a point that women should be made aware that they have the right to accept or decline any part of any of the screening programmes. We have also added screening programmes to the list of issues to discuss and provide information on at the first antenatal

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					appointment. We have also revised the evidence report accordingly.
Don't Screen Us Out	Evidence Review G	General	General	This Evidence Review could also be usefully informed by and include the research commissioned by PHS carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic.
Don't Screen Us Out	Evidence Review H	013	Table 2 3rd Bullet	'including risks and benefits of the screening tests' Both occurrences should be extended to include information about screened for conditions otherwise informed consent may not be possible in some cases.	Thank you for this comment. The committee revised the recommendations to make it clear that information about screening programmes should be shared and discussed at the first antenatal appointment. Information provision and discussion was also included in the recommendation about offering screening programmes.
Don't Screen Us Out	Evidence Review O	General	General	Consideration should be made of the use of 'congenital abnormalities' where it should say 'congenital anomalies'	Thank you for this comment. This has been amended as suggested.

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Don't Screen Us Out	Evidence Review O	016	003	The reference to 'normal size babies' in 'Content' could more sensitively say 'average size babies' or similar.	Thank you for this comment. The use of the words 'normal size babies' is present in the pre-defined review protocol and cannot be amended afterwards. Otherwise, we have revised the language throughout the report according to your suggestion, where appropriate.
Don't Screen Us Out	Evidence Review W	General	General	Consideration should be made of the use of 'congenital abnormalities' where it should say 'congenital anomalies'	Thank you for this comment. The language has been revised according to your suggestion, where appropriate. The language has not been changed in two places: in the pre-defined review protocol which we have not amended for transparency, and in evidence tables which documents the data as reported in studies included in the review.
Don't Screen Us Out	Guideline	General	General	This is a very comprehensive guidance; we would just like to see the review of some terminology and the addition of reference to more information for women. We attach specific comments about the consultation papers below. This is also an opportune time to review the hosting of this guidance to ensure that it is visible to a greater number of healthcare professionals involved in antenatal care. There are 3 publications which could usefully be added and inform the new guidance: Down's syndrome Scotland 2017 Health Survey "Listen to Me, I have a Voice" which discusses information and support issues that women	Thank you for this comment. We have reviewed the terminology in the evidence reviews. Thank you for providing the references of potentially relevant studies, which we have cross checked with our search strategy and inclusion/exclusion criteria. The quoted references do not match the review protocols so cannot be included. Please see below for reasons for exclusion: https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf- this reference would not be flagged in this review as the scope of the guideline did not

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				encountered during pregnancy and at birth https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf DSUK 2019 "Sharing the News" report https://www.downsyndromeuk.co.uk/flipbook.html Research commissioned by PHS carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." This study found a lack of knowledge among pregnant women about screened-for conditions such as T13, T18 and T21 http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf Regarding women with positive antenatal results for fetal anomaly, Nuffield Council of Bioethics 2017 report on NIPT recommends: "the National Institute for Health and Care Excellence (NICE) should produce clinical pathway guidance on the continuation of pregnancy after diagnosis of fetal anomaly." https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing There needs to be mention in the guidance under review as to plans for development of this much needed pathway as NIPT is rolled out on an evaluative basis and the work is informed by Nuffield's work in the area of antenatal screening.	include a qualitative question about experiences of healthcare staff. https://www.downsyndromeuk.co.uk/flipbook.html- this reference would not be flagged in this review as the scope of the guideline did not include a question about the experiences of women who have a baby with Down's syndrome http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. This reference does not match the inclusion criteria of the evidence reviews in this guideline and therefore cannot be included. https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing- this reference did not appear in the review's search results as this reference is a narrative report of working group discussions. This study design does not fit the protocol for any of the evidence reviews for this guideline.

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				In answer to the question about cost we would suggest that greater emphasis on mandating training for staff about living with screened-for conditions would have a cost implication. This would obviously be outweighed by the benefit of a more informed workforce and public, and would respond to the recommendation made by Nuffield Council of Bioethics in their 2017 report on NIPT: 'High quality education and training must be compulsory for all health and social care professionals involved in NHS prenatal screening.' As stated previously, Nuffield's work in the area of screening will inform the evaluative rollout of NIPT.' https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing	
Donna Southam	Guideline	014-015	General	There is no reference to auscultating the fetal heart at antenatal appointments. I know in the current guidance it is not recommended unless the woman asks however the vast majority I have observed wish to hear their baby's heart beat during an antenatal appointment. It is mainly common practise when Midwives and Obstetricians auscultate the fetal heart rate they do not palpate the pulse at the same time. This provides no reassurance whose heart beat was heard. I have undertaken several investigations in my career where a fetal heart beat was heard and no pulse was palpated. When the woman was referred to the hospital there was an absent fetal heart beat. Whilst palpating the maternal pulse would	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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				not have prevented the outcome, it provides false reassurance to the woman and confusion as to when the baby had died. Clear guidance needs to be provided to health professionals that when they auscultate the fetal heart, a maternal pulse should be palpated to differentiate between mother and baby	
Down Syndrome Research Foundation UK	Draft Guideline	General	General	This is a truly comprehensive and wide-reaching guidance; we would just like to see the review of some terminology in all of the Review papers, as guidance should show awareness of non-discrimination and equality law, plus the addition of reference to more information for women. Abnormal, disorder and risk should all be considered as to their suitability. This is also an opportune time to review the hosting of this guidance to ensure that it is visible to a greater number of healthcare professionals involved in antenatal care. There are several publications which could usefully inform the new guidance: Down's syndrome Scotland 2017 Health Survey which explores experiences of women during pregnancy and after birth https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf DSUK's 2019 Sharing the News report https://www.downsyndromeuk.co.uk/flipbook.html Scott Porter research carried out in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice	Thank you for this comment. We have reviewed the terminology in the evidence reviews and revised where appropriate. Thank you for providing the references of potentially relevant studies, which we have cross checked with our search strategy and inclusion/exclusion criteria. The quoted references do not match the review protocols so are not relevant for inclusion. Please see below for reasons for exclusion: https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf- this reference would not be flagged in this review as the scope of the guideline did not include a qualitative question about experiences of healthcare staff. https://www.downsyndromeuk.co.uk/flipbook.html- this reference would not be flagged in this review as the scope of the guideline did not include a question about the experiences of women who have a baby with Down's syndrome

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				about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." This study uncovered limited knowledge among pregnant women about screened-for congenital anomalies. This is an issue that HCPs will be challenged by. http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf Regarding women with confirmed antenatal results for fetal anomaly, Nuffield Council of Bioethics 2017 report on NIPT recommends: "the National Institute for Health and Care Excellence (NICE) should produce clinical pathway guidance on the continuation of pregnancy after diagnosis of fetal anomaly." https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing The guidance must include reference to plans for development of this much needed pathway as NIPT is rolled out on an evaluative basis and the work is informed by Nuffield's work in the area of antenatal screening (2017 Report on NIPT). In answer to the question about cost we would suggest that greater emphasis on mandating training for staff about living with screened-for conditions would have a cost implication. This would obviously be outweighed by the benefit of a more informed workforce and public, and would respond to the recommendation made by Nuffield Council of Bioethics in their 2017 report on NIPT: 'High quality education and training	http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. The inclusion criteria of this reference do not match those of the evidence reviews in this guideline and therefore cannot be included. https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing- this reference did not appear in the review's search results as this reference is a narrative report of working group discussions. This study design does not fit the protocol for any of the evidence reviews for this guideline.

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				must be compulsory for all health and social care professionals involved in NHS prenatal screening.' As stated previously, Nuffield's work in the area of screening will inform the evaluative rollout of NIPT.' https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing The Conflict of interests requirement should include a question about links with Commercial companies in the fertility or antenatal testing sector.	
Down Syndrome Research Foundation UK	Evidence Review A	014	027	'Fetal disorder' 'pregnancy risks' this isn't standard wording and should say 'fetal anomaly' and 'chance' instead of 'risk' in line with Public Health England standards.	Thank you for this comment. We have amended the language in line with your suggestion.
Down Syndrome Research Foundation UK	Evidence Review A	014	029	'This meant that some older pregnant women sometimes found it difficult to remain positive.' To counter this, new guidance should clarify that Health Care Professionals should not refer to abnormalities, disorders, risks etc in discussions with women. Guidance should also refer to the sensitivities of pregnant women and their difficulty in remaining positive at times. DSUK's 2019 Sharing the News report has helpful content https://www.downsyndromeuk.co.uk/flipbook.html	Thank you for this comment. The guideline emphasises the importance of respectful, sensitive and considerate discussions and information provision, tailored according to the individual needs and preferences of the woman. Cross-references to the NICE guideline on patient experience in adult NHS services, in particular the sections on communication, information and shared decision-making have been added. The committee have also added a recommendation about the importance of

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					listening to women and responding to their needs and preferences.
Down Syndrome Research Foundation UK	Evidence Review A	015	014	'pregnant women considered midwives the designated caregivers for health education, and considered them reliable sources of important information.' Guidance should recommend that midwives undergo mandatory and continuing professional development training around the lived-experience with congenital conditions in line with recommendation made by Nuffield Council of Bioethics 2017 report on NIPT: 'High quality education and training must be compulsory for all health and social care professionals involved in NHS prenatal screening.' https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing	Thank you for this comment. Training of healthcare professionals is generally outside the remit of NICE although guidelines do occasionally comment on the expertise needed to deliver care or a specific intervention. Therefore, this was not a topic that was included in the scope of this guideline.
Down Syndrome Research Foundation UK	Evidence Review A	022	Table 3	Table 5 and the guidance would benefit from a theme being added re the issue of women finding it difficult to remain positive. Down's syndrome Scotland 2017 Health Survey highlights experiences of women with positive antenatal results for Down's syndrome and also after birth https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf and DSUK's 2019 Sharing the News report https://www.downsyndromeuk.co.uk/flipbook.html are helpful links for this theme. This theme could also consider results of Scott Porter's 2019 research "Establishing the information needs of pregnant women and their partners	Thank you for this comment. Thank you for providing the references of potentially relevant studies, which we have cross checked with our search strategy and inclusion/exclusion criteria. The quoted references do not match inclusion criteria in the review protocols so have not been included in the review. Please see below for reasons for exclusion: https://www.dsscotland.org.uk/wordpress/wp-content/uploads/2017/03/DSS-Listen-to-Me-pdf.pdf- this reference would not be flagged in this review as the scope of the guideline did not

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				to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." Researchers uncovered limited knowledge among pregnant women about screened-for congenital anomalies http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	include a qualitative question about experiences of healthcare staff. https://www.downsyndromeuk.co.uk/flipbook.html- this reference would not be flagged in this review as the scope of the guideline did not include a question about the experiences of women who have a baby with Down's syndrome http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. The inclusion criteria of this reference do not match those of the evidence reviews in this guideline and therefore cannot be included.
Down Syndrome Research Foundation UK	Evidence Review A	051	Table 5	This Evidence Review paper could be informed by and include the research carried out by Scott Porter in 2019 "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this

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					level of detail in their discussions and did not review evidence on this topic. Furthermore, the quoted reference does not match the inclusion criteria in this particular review protocol so it was not included. Please see below for reason for exclusion: http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. This reference does not match the inclusion criteria of the evidence reviews in this guideline and therefore cannot be included.
Down Syndrome Research Foundation UK	Evidence Review B	General	General	Unexpected information should be mentioned in this table to give Health Care Professionals an indication of how a woman may react in the first instance and for them to realise that feelings may change over time and that support is needed.	Thank you for this comment. This comment seems to refer to the information in the protocol. As the protocol is pre-defined and we are unable to change what is listed in the intervention section. However, the current list provides a few examples of specific aspects to providing information and support as a guide for the review, and was not intended to be exhaustive. We would not have excluded any studies that looked at, for example, Downs Syndrome and

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					information provision on screening results, where 'unexpected information' could fall. How women react to unexpected information could have also been captured in Review A. This review focused on the views and experiences of women on the information they received during their antenatal care. Evidence relating to how women experienced unexpected information would have been captured and reported by this review if it was available.
Down Syndrome Research Foundation UK	Evidence Review B	General	General	'Severe fetal morbidity' should be replaced with more meaningful, more commonly used wording which may ensure that the reference is more productive.	Thank you for this comment. The use of the words 'severe fetal morbidity' is present in the pre-defined review protocol and has therefore not been amended afterwards, however, it should be noted that the literature search and the subsequent evidence review was not bound by this particular terminology alone.
Down Syndrome Research	Evidence Review C	General	General	Scott Porter's 2019 research "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and

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Foundation UK				programme." They uncovered limited knowledge among pregnant women about screened-for congenital anomalies http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic. Furthermore, the quoted reference does not match the inclusion criteria in this particular review protocol so has not been be included. Please see below for reason for exclusion: http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf- this reference did not appear in the review's search results as this reference seeks the opinions of women and their partners on information specific to NIPT/T13/T18. This reference does not match the inclusion criteria of the evidence reviews in this guideline and therefore cannot be included.
Down Syndrome Research Foundation UK	Evidence Review F	General	General	Scott Porter's 2019 research "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme." They uncovered limited knowledge among pregnant women	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be

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				about screened-for congenital anomalies http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic. Furthermore, the research you suggest is of a qualitative study design which does not meet our criteria as set out in the protocol for this review so it was not included in the review.
Down Syndrome Research Foundation UK	Evidence Review F	General	General	A recommendation made by Nuffield Council of Bioethics in their 2017 report on NIPT would have some bearing on the antenatal appointment journey for women continuing pregnancy (following a confirmation of congenital anomaly). Nuffield's work is intended to inform the NIPT implementation: 'National Institute for Health and Care Excellence (NICE) should produce clinical pathway guidance on the continuation of pregnancy after diagnosis of fetal anomaly.' https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing	Thank you for this comment. This guideline covers routine antenatal care for all women however, specialist care is outside the scope of this guideline. Therefore, we are unable to include information on a clinical pathway or the continuation of pregnancy after diagnosis of fetal anomaly. However, the committee added a recommendation which states that if there are any unexpected findings from examinations or investigations, referral should be offered according to local pathways and appropriate information and support should be provided.
Down Syndrome Research	Evidence Review G	General	General	Importantly, this Evidence Review paper should state a requirement for information about screened-for conditions to ensure informed consent, as required,	Thank you for this comment. We have revised the recommendation on offering screening programmes to include this important point about providing information and discussion to

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Foundation UK					allow for an informed decision making. We have also added a point that women should be made aware that they have the right to accept or decline any part of any of the screening programmes. We have also added screening programmes to the list of issues to discuss and provide information on at the first antenatal appointment. We have also revised the evidence report accordingly.
Down Syndrome Research Foundation UK	Evidence Review G	General	General	Scott Porter's 2019 research "Establishing the information needs of pregnant women and their partners to support informed choice about Patau's syndrome (trisomy 13), Edwards' syndrome (trisomy 18) and non-invasive prenatal testing (NIPT) to the Scottish pregnancy screening programme.' They uncovered limited knowledge among pregnant women about screened-for congenital anomalies http://www.healthscotland.scot/media/3111/pataus-syndrome-edwards-syndrome-and-nipt-research.pdf	Thank you for this comment. Based on your and other stakeholders' comments the committee revised the recommendations around screening so that it is clear that information around screening programmes should be given and discussed so that an informed decision can be made by the woman. The resource you provide a link to might include helpful information in relation to what and how information about screening programmes should be provided, however, the committee did not consider this level of detail in their discussions and did not review evidence on this topic.
Down Syndrome Research	Evidence Review H	013	Table 2	'including risks and benefits of the screening tests' this point would benefit from the reference to the inclusion of information about screened for conditions to ensure informed consent, as required.	Thank you for this comment. The committee revised the recommendations to make it clear that information about screening programmes should be shared and discussed at the first antenatal appointment. Information provision

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Foundation UK					and discussion was also included in the recommendation about offering screening programmes.
Down Syndrome UK	Evidence Review A	014	026-030	'Similarly, some older pregnant women felt anxious when they received too much information about the risks of fetal disorders and other age-related pregnancy risks. Reading and having access to too much information gave light to concerns that they had previously not considered. This meant that some older pregnant women sometimes found it difficult to remain positive. ' Risks and disorders – negative biased language that is offensive and should be changed to the change of fetal differences We provide peer support to expectant women with a high chance/confirmed result of baby having Down syndrome. We are currently supporting 86 women across the UK and they regularly comment on the overriding negative language and attitudes towards them/baby having Down syndrome. NICE has an opportunity to address this discrimination by making it crystal clear, every woman must be treated with respect and discriminatory, directive language and attitudes are not tolerated. This will improve the likelihood of women remaining positive. Please refer to our report that publishes the findings of 1,410 women in the UK who have had a baby with Down syndrome: Sharing the News the maternity experience of having a baby with Down syndrome	Thank you for this comment. We have amended any negative biased language in line with your suggestion.

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Down Syndrome UK	Evidence Review A	015	014	Our evidence shows that too many medical professionals do not have a contemporary accurate understanding of Down syndrome. The Guidance should state that midwives and other health care professionals involved in antenatal care should undergo mandatory and CPD training about the conditions screened for in pregnancy; with training delivered by those with lived experience of the condition.	**Thank you for this comment. Training of healthcare professionals is generally outside the remit of NICE although guidelines do occasionally comment on the expertise needed to deliver care or a specific intervention. Therefore, this was not a topic that was included in the scope of this guideline.**
Down Syndrome UK	Evidence Review C	General	General	Review and amend use of 'normal' and 'risk'	Thank you for this comment. The language has been revised according to your suggestion, where appropriate. The use of the word 'risk' is present in evidence tables as reported in studies included in the review.
Down Syndrome UK	Evidence Review H	013	Table 2	'including risks and benefits of the screening tests' Both should include accurate contemporary information about the conditions being screened for.	Thank you for this comment. The committee revised the recommendations to make it clear that information about screening programmes should be shared and discussed at the first antenatal appointment. Information provision and discussion was also included in the recommendation about offering screening programmes.
Down Syndrome UK	Evidence Review O	General	General	Revise 'congenital abnormalities' to 'congenital anomalies'	Thank you for this comment. This has been amended as suggested.
Down Syndrome UK	Evidence Review O	016	Table 3	Revise 'normal size babies' to 'typical or average size babies'	Thank you for this comment. The use of the words 'normal size babies' is present in the pre-defined review protocol and cannot be amended afterwards. Otherwise, we have revised the

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					language throughout the report according to your suggestion, where appropriate.
Down Syndrome UK	Evidence Review W	General	General	Revise 'congenital abnormalities' to 'congenital anomalies'	Thank you for this comment. The language has been revised according to your suggestion, where appropriate. The language has not been changed in two places: in the pre-defined review protocol which we have not amended for transparency, and in evidence tables which documents the data as reported in studies included in the review.
Down Syndrome UK	Guideline	General	General	We have evidence that there is systemic discrimination towards Down syndrome in maternity care that we would urge NICE to address in the new guidelines. Please refer to our publication Sharing the news – the maternity experience of having a baby with Down syndrome The report published the findings of the lived experience of 1,410 women who have had a baby with Down syndrome in the UK and highlights the frequency of negative, directive language and discriminatory attitudes towards them. Key findings that NICE should seek to address: An assumption that women should terminate - on receiving news that the baby has Down syndrome	Thank you for this comment. We have revised the language used based on your and other stakeholders' comments so that it is more sensitive. We have also revised the recommendations on screening programmes to be more explicit that information about the screening programmes should be given and discussed to enable informed decision making and also that the woman should be made aware that she can accept or decline any part of any of the screening programmes. The language used in the screening programme is outside the remit of NICE.

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				• 69% of women were offered a termination. • After advising they were continuing with the pregnancy 46% of women were asked again if they wished to terminate. An assumption that women should have further testing & disregard of women's choices - on receiving news that the baby had a high chance of having DS (greater than 1:150) • 91% of women were offered further tests. • Of those who declined further tests, 44% felt under pressure to test further. • After advising they were continuing with the pregnancy 50% of women were offered termination again. Misinformation regarding antenatal screening • 41% of women were of the understanding that screening for Down syndrome is a routine element of their antenatal care. • 41% of women advised professionals they did not want to screen for Down syndrome, but screening was mentioned again to 49% of these women. Lack of relevant information • Most expectant parents, after being advised there's a high chance baby has Down syndrome, 56% are sent home without relevant literature. Lack of support	

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				• Two thirds of the expectant women did not receive any counselling or form of support	
Down Syndrome UK	Guideline	General	General	Throughout antenatal care when discussing the likelihood of baby having Down syndrome, language should be respectful to those who have Down syndrome. For all patient facing communication, one must consider the impact of medically defined language. Whilst an abnormality may be appropriate in oncology, it is not appropriate when referring to a woman's pregnancy affected by Down syndrome. Like wise the use of disorder, and risk when referring to the chance/likelihood of baby having Down syndrome. Not only are such terms offensive and disrespectful to those with Down syndrome, but the impact on expectant parents cannot be underestimated – having your pregnancy referred to as abnormal is distressing and can have a very negative impact on the mental health, general wellbeing of expectant parents. We trust NICE will use this opportunity to categorically state that when there are discussions with regard to Down syndrome, language must be factual and actual.	Thank you for this comment. We have revised the language throughout, for example we have changed 'congenital anomalies' to 'congenital abnormalities' and avoided to use the word 'risk' in relation to congenital abnormalities.

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				When women are given screening results they must be presented in a non directive manner – this must be stated in NICE guidelines, as our evidence shows that too often it is presented in a directive manner. There must be emphasis on medical professionals ensuring language is unbiased, respectful and non-discriminatory. Sharing the News the maternity experience of having a baby with Down syndrome	
Down Syndrome UK	Guideline	General	General	We are concerned at the continued absence of national care pathway for those continuing a pregnancy affected by Down syndrome Please reference St George University Hospital Trust's pathway – Personalised antenatal care of pregnancies suspected or diagnosed with Down syndrome	Thank you for this comment. This is outside the scope of this guideline and therefore this has not be commented on.
Down Syndrome UK	Guideline	General	General	We are concerned that the Nuffield Council of Bioethics 2017 report on NIPT recommended: 'The National Institute for Health and Care Excellence (NICE) should produce clinical pathway guidance on the continuation of pregnancy after diagnosis of fetal anomaly.'	Thank you for this comment and for your suggestion for an additional NICE guideline on continuation of pregnancy after diagnosis of fetal anomaly. The process for identifying and prioritising NICE guidelines is as follows: A topic selection oversight group at NICE considers topics for guideline development taking a number of factors into account, as set

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				However, 4 years later and this pathway has not been produced – why not? This must be prioritised and included, women deserve better care than they currently receive	out in the NICE Guidelines Manual. NICE then discusses topics identified in this way with NHS England, the Department of Health and Social Care, and Public Health England, and a prioritised list is agreed by these 3 bodies. Topics are then formally referred to NICE. A Cross-Agency Prioritisation Group was established in 2020 and held its first meetings in 2021. The group is working to finalise new principles to determine how topic referrals and guidelines identified for update within our existing portfolio can be scheduled, based on their relative priority and value to the health and social care system, taking into account the emergence and availability of new evidence.
Down Syndrome UK	Guideline	011	001-016	Our evidence shows expectant women are not provided with accurate contemporary information regarding Down syndrome. This needs to be addressed by medical professionals receiving mandatory training and CPD, delivered by those with lived experience of Down syndrome. 'Most expectant parents, after being advised there's a high chance baby has Down syndrome, 56% are sent home without relevant literature.' Publication Sharing the news – the maternity experience of having a baby with Down syndrome	Thank you for this comment. The recommendations were revised so that it is clear that information about all the screening programmes are offered and discussed. The expectation is that this should be accurate and up to date. Training of professionals is not in the remit of this guideline so we have not commented on it.

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Fatherhood Institute	Guidance	8	003-011 0013 016 018 019	Taking the family's' history 1.2.1 At the first antenatal (booking) appointment, ask the woman (and her partner/ the future parent if present) about: • Their medical history, obstetric history and family history . . . • Their occupations, discussing any risks and concerns • Their home situation and the support the woman has – etc. (N.B. most of the phrasing in this list 'works' for both partners or just the woman.) *Rationale: A wealth of literature – NICE might consider compiling an Evidence Review – shows the powerful impact that the pregnant woman's partner has on her (and the unborn child). Other than in exceptional; circumstances, the father/partner usually has FAR more influence than wider family. The biological father's family history (including histories of miscarriage, genetic issues) and family mental health vulnerabilities and allergies all need to be known and recorded by the service – as will also be the case when the pregnant woman's partner is the biological mother of the child.*	Thank you for this comment which the committee discussed. The committee agreed that there may be relevant issues around the father's/other genetic parent's family history as well so this has been added to the recommendation. The committee also agreed that it is important to enquire about any issues related to the partner or other family members which might have an impact on the wellbeing of the woman, including mental health concerns, other illness and so on. The recommendation was revised accordingly.
Fatherhood Institute	Guideline	Page 10	010	• ask the woman (and her partner, if present) if they have any concerns they would like to discuss *Rationale:* *It is very important that the pregnant woman has a safe space (without her partner present) to discuss issues and concerns from time to time. Most partners will not be at all antenatal care appointments so there should be ample opportunity for this. But also bear in mind that the father/partner is the*	Thank you for this comment. The committee agrees and added this to the recommendation.

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				'first responder' when trouble is brewing, and also holds unique knowledge about the pregnant woman. Opportunities for the partner/ future parent to share information/ perspectives should be encouraged	
Fatherhood Institute	Guideline	006	005	After • include contact details about the woman's GP Add • include contact details about the woman's partner/ future parent *Rationale: the woman's partner is relevant not just to support the woman (a 'partner') but because of their own unique relationship to the infant ('future parent'). In the case of the biological father (95% of whom are in a couple relationship with the woman during the pregnancy) or a lesbian woman (1:1000 per year) whose partner is carrying her biological child) their genetic bequests will also be of importance. Practice seems to vary from maternity services that record both parents' details to those that do not ever record those of the father/ woman's partner. A clear instruction from NICE would remedy that. It would be important to make clear that whether or not the mother provides this information is entirely voluntary.*	Thank you got this comment. Asking for the contact details for her partner and her next of kin have been added to the list. The committee also added asking about the baby's future parental carers to the list.
Fatherhood Institute	Guideline	006	007	After • Offer a first antenatal (booking) appointment with a midwife Add 'making clear that if the woman so wishes, her partner is invited to attend.'	Thank you for this comment. The committee's recommendations on inviting partners to appointments, if the woman wishes, is covered in the 'involving partners' section of the guideline.

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				Rationale: involving the partner/ future parent from the outset, rather than suggesting in some ad hoc way that they be invited along at some point, will establish systematic engagement with the woman's partner/ future parent.. Systematic engagement is needed to deliver best outcomes for maternal and infant health.	
Fatherhood Institute	Guideline	006	017	After • Offer additional or longer antenatal appointments if needed, depending on 1the woman's medical, social and emotional needs Add "including vulnerabilities/ behaviours identified in her partner that may impact the woman" *Rationale: if the woman's partner smokes, uses alcohol or drugs, has poor mental health, uses violence or other controlling behaviours, such behaviours and vulnerabilities should be interpreted as posing a risk to the woman and should be part of risk assessment.*	Thank you for this comment. The committee discussed that 'social' or 'emotional' needs would encompass issues that might relate to the partner which impact the woman and thus would allow discussion of any behaviours or vulnerabilities that could present as a risk to the woman.
Fatherhood Institute	Guideline	007	003	After • Involving partners Add "/ future parents" *Rationale: 'Partner' refers to the woman's chosen supporter. This is most often the baby's other parent, but can also be another family member or friend, or anyone whom the woman feels supported by and wishes to involve in her antenatal care. Partners who are entering a role as parent of the baby have*	Thank you for this comment. The word 'partner' has been defined in the 'terms used' section of the guideline.

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				particular needs and perspectives and, as 'future parents' need to be thought of in that role.	
Fatherhood Institute	Guideline	Page 9	020	• If the woman or her partner smokes or has stopped smoking within the past 2 weeks, refer them to NHS Stop Smoking *Rationale: there is a wealth of evidence that referring one part of a couple for smoking cessation is less effective than referring both. There is also the issue of second-hand smoke during the pregnancy and afterwards, once the baby is born.*	Thank you for this comment, we have made the suggested change.
Fatherhood Institute	Guideline	016	010	• Communication with women and their partner *Rationale: this section is headed up "Information and support for pregnant women and their partners" so you need to follow through on that in this section*	Thank you for this comment. We have revised the heading of this section.
Fatherhood Institute	Guideline	016	016	• offered on a one-to-one/ couple basis *Rationale: this section is headed up "Information and support for pregnant women and their partners" so you need to follow through on that in this section*	Thank you for this comment, we have revised the wording. We meant woman and her partner, if present.
Fatherhood Institute	Guideline	017	010-012	• Check that the woman (and her partner, if present) understand the information that has been given, and how it relates to her. Provide regular opportunities for questions and set aside enough time to discuss any concerns. *Rationale: this section is headed up "Information and support for pregnant women and their partners" so you need to follow through on that in this section*	Thank you for this comment. We have revised the wording as suggested.
Fatherhood Institute	Guideline	017	015	• women *or their partners* who misuse substances	Thank you for this comment. This recommendation refers to a specific NICE

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				Rationale: there is a wealth of evidence on substance misuse being a 'family affair' whether through both partners abusing substances or a non-user being co-dependent. At the very least both partners, where one misuses substances, should be referred for support. AA / NA and Al-Anon are universally available.	guideline which covers women who misuse substances, therefore we have not added their partners as they are not covered by the guideline. However, in order to avoid further confusion, we have revised the wording in the recommendation and moved the recommendation to a more appropriate section in the guideline.
Fatherhood Institute	Guideline	017	018	• young women aged under 20 or whose partner is a teenager/ young father (aged under 25) *Rationale: very often a teenage woman's partner is in his early twenties but may be immature and is often vulnerable. So slightly older young men/boys also tend to be given special consideration – as also boys who are younger than the teenage mother (this is quite common).*	Thank you for this comment. This recommendation refers to a specific NICE guideline which covers young women under 20, therefore we have not added partners who are young, as they are not covered by the particular guideline. However, in order to avoid further confusion, we have revised the wording in the recommendation and moved the recommendation to a more appropriate section in the guideline.
Fatherhood Institute	Guideline	019	008-009	Bonding and attachment. You refer to 'parents' in the plural here – i.e. • how the parents can bond with their newborn baby and the importance 8 of emotional attachment	Thank you for this comment. The definition of bonding and emotional attachment have been carefully thought and edited and we do not think there should be any major confusion.

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				However, the text in the 'Terms used in this Guideline / Bonding and emotional attachment' on page 30 (to which one is taken via the link), moves uncomfortably between singular and plural.	
Fatherhood Institute	Guideline	030	016	*This section is not only awkward because of this and because the text is not clear. It should be re-written. We understand that it is part of another guideline, but the wording there now is not the same as a few months ago, when the postnatal guideline was out for consultation. It seems to have been amended since then – but needs to be amended further! Here is a suggestion*: Bonding is the positive emotional and psychological connection that mothers and fathers and other major caregivers develop with an infant or child. Emotional attachment refers to the relationship between the infant/ child and their close caregiver(s). The development of an emotional attachment is a complex and dynamic process dependent on sensitive and emotionally attuned caregiver responses. The development of a secure attachment is associated with healthy infant/ child psychological and social development. Insecure attachments, by contrast, result from negative caregiver responsiveness and behaviours, and can lead to chronic psychosocial problems. Babies form attachments with a variety of caregivers. The earliest and most significant is usually with their mother and then (or	Thank you for this comment. The definition of bonding and emotional attachment derives from the NICE postnatal care guideline and has been aligned with the definition in that guideline. The definition is meant to be concise and has been carefully reviewed and edited based on expert views, stakeholder comments and NICE editorial approaches.

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				simultaneously, depending on amount and regularity of care), their father/ the other parent. *Rationale: all secure attachments benefit babies; all insecure attachments damage them. It is important to address attachment in both parents early on. The literature is clear: that infants develop simultaneous but individual attachments with major caregivers.*	
Fiona Tankard	Guideline	029	General	The guidance about pelvic girdle pain is extremely concerning. As a woman who experienced PGP in two pregnancies, I know for a fact that exercises and a belt do not work. It was only when I had manual physiotherapy from a private physiotherapist that I gained relief. It is now widely accepted that Pelvic Girdle Pain can and should be treated with manual physiotherapy and offering a belt and / or exercises is completely inadequate and can actually do more harm than good if the woman tries to exercise on asymmetric joints or grips the pelvis in a misaligned position. The only reason NHS physiotherapists think this is successful is because the women in pain do not bother to go back as this is not treatment, and it is not effective. The diagnosis and treatment of PGP has improved greatly in the last few years, and the need for manual therapy is recognised by RCOG and POGP, but a large number of midwives still promote the idea that nothing can really be done. I sincerely hope that NICE will seize the opportunity to recognise and promote the effective treatment of a condition which causes a great deal of lost income for women during and	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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				after pregnancy, not to mention the massive mental health impact of being in pain and told that nothing can be done when in fact PGP is eminently treatable.	
Group B Strep Support	All	All	All	The final scope says *"This guideline is applicable to all pregnant women, including those with maternal and/or fetal conditions. This is because these women will need normal antenatal care alongside specialised care, which is not covered in this guideline."* Repeated stakeholder comments on the draft scope requested that the GDG include guidance on caring for pregnant women before a risk factor for GBS infection is identified, including what information is provided, when and by whom. This is not included in the Neonatal Infection Guideline and the RCOG published an updated Greentop on Group B Strep and RCOG recommended that all women should be provided with an information leaflet on Strep b. In response to this and similar comments, the NICE team responded repeatedly with the same paragraph *"Screening recommendations are issued by the UK National Screening Committee (UK NSC) and their latest recommendations include not screening pregnant women for group B streptococcus (GBS). We will signpost this information in this guideline."*	Thank you for this comment. The committee agreed to revise the recommendation on information provision at booking appointment (and later if appropriate) that pregnant women should be given information about infections that might impact the baby including group B streptococcus.

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				None of the stakeholders raised the issue of whether screening should or should not be performed. They requested the inclusion of guidance around information provision on group B Strep to pregnant women, regarding their care, specifically related to GBS infection irrespective of testing. Despite these assurances, there is no reference at all to group B Strep in the draft guideline, and no signposting for health professionals or for families who want guidance or information on group B Strep to the RCOG Greentop guideline, to the NICE Neonatal Infection Guideline or to Group B Strep Support. This ignores the specific recommendation of the RCOG guideline that all pregnant women should be provided with such information, which the RCOG co-wrote with GBSS in the form of a leaflet which they recommended should be given free to all women during their pregnancy. We consider that women have a right to be informed about this risk to their babies irrespective of the availability or otherwise of testing. Please correct this.	
Healthcare Safety Investigation Branch	Guideline	General	General	Risk assessment: in the light of the essential actions outlined in the recent Ockendon review is there a need for NICE to explicitly advise: Staff must ensure that women undergo a risk assessment at each contact throughout the	Thank you for this comment which the committee discussed. The committee agreed that overall risk assessment is and should be done at each appointment and this has now been made explicit in the guideline.

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				pregnancy pathway.	
Healthcare Safety Investigation Branch	Guideline	General	General	We have noted that throughout the document that reference to ethnicity is not always in line with government guidance: Writing about ethnicity - GOV.UK (ethnicity-facts-figures.service.gov.uk) Examples include capitalisation when referring to ethnic groups.	Thank you for this comment. The NICE style is to only capitalise proper nouns, legislation, questionnaire titles, projects, campaigns and brands. The NICE style guide does not provide specific guidance on whether to capitalise ethnic groups, but it does provide examples about how to talk about where a person is from. The NICE style guide has been developed with input from Gov.uk's style guide (as well as other sources), but it does not follow Gov.uk's style guide to the letter because NICE often talks about people in a different context to the Government. In the case of family background and ethnicity, NICE follows the NHS style guide, specifically the examples on the inclusive language page and the NHS glossary for racial literacy, in which 'black' and 'white' are not capitalised. Although none of these resources include an instruction saying 'do not capitalise', the NICE style guide follows their examples. NICE is constantly researching and redeveloping its style guide to take into account developments in language from various sources – the news,

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					government reports, the NHS language matters, and academic papers – as well as people's views. NICE is including the stakeholder comment as part of this ongoing research, so it will directly feed into NICE's ongoing research on capitalisation and ethnicity.
Healthcare Safety Investigation Branch	Guideline	006	012-016	Having 7 appointments for parous women does not allow for 2-3 weekly SFH measurements for screening for SGA. The study quoted by 'Evidence review I' on the effect on detection of IUGR for reduced antenatal appointments, had only 81 women. HSIB investigations have observed inconsistencies in the variation of screening for IUGR - this includes gaps in intervals between taking and plotting SFH measurements, which is not in line with the guidance that most trusts are using in order to screen for SGA. This has resulted in missed opportunities to detect SGA antenatally, and re-evaluate an intrapartum care plan.	Thank you for this comment. No evidence was identified that would support increasing the number of routine antenatal appointment for parous women from current practice. Furthermore, SFH measurements were not found to be particularly accurate in detecting small for gestational age babies so there is little ground to change current practice in terms of the number of routine appointments due to SFH measurements.
Healthcare Safety Investigation Branch	Guideline	008	005	HSIB investigations have observed that a review of a woman's previous obstetric history does not always include review of her previous maternity records, for example when previous maternity care has been in a different organisation. This has led to plans of care based on an inaccurate risk assessment; for example, a previous shoulder dystocia has not been recognised.	Thank you for this comment. The committee added a recommendation to consider reviewing her previous medical records and added further explanation, including the example that you gave, in the 'Why the committee made the recommendations' section.

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Healthcare Safety Investigation Branch	Guideline	014	015-018	HSIB investigations have observed events where not acting in response to possible SGA from SFH measurements has contributed to a poor outcome. As above, clear parameters would support clinical decision making in response to SFH plotting.	Thank you for this comment. The committee discussed this at length during the development of the guideline and concluded that given the evidence that was reviewed, they were not able to give more detailed guidance on what the cut-offs for concern would be.
Healthcare Safety Investigation Branch	Guideline	014	012-013	HSIB investigations have observed a lack of consistent opinion on what constitutes LGA from SFH plotting; clinicians require clarification about when LGA should be considered, based on SFH measurements, and the action that is required in response.	Thank you for this comment. The committee discussed this at length during the development of the guideline and concluded that given the evidence that was reviewed, they were not able to give more detailed guidance on what the cut-offs for concern would be.
Healthcare Safety Investigation Branch	Guideline	014	005	RCOG guidance has been superseded by NHS Saving Babies Lives care bundle v2; the implementation of this being a requirement of MIS (NHSR) Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf (resolution.nhs.uk). Can this be amended to remove the reference to RCOG guidance?	Thank you for this comment. The references are examples of risk assessment tools used. The committee's view is that both examples can be provided and the RCOG guidance is still available and accredited by NICE.
Healthcare Safety Investigation Branch	Guideline	014	009	One current IUGR screening project suggests SFH measurement at 26-28 weeks (GAP/GROW) – could this be amended to state instead: SFH measurements to be initiated from 24-28 weeks.	Thank you for this comment. The recommendation says to start measuring SFH from 24+0 weeks so we think this is sufficient (parous women would generally not have an appointment until 28 weeks anyway). The

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				In relation to offering SFH measurement: consider adding "and plot on a growth chart". HSIB investigations have observed that when SFH measurements are not consistently plotted on a growth chart (population or customised), this may contribute to non-recognition of fetal growth restriction and missed opportunities to amend a woman's care plan.	committee agreed to add that the measurements should be plotted to a growth chart.
Healthcare Safety Investigation Branch	Guideline	015	012	HSIB investigations have observed that the identification of a breech presentation once labour has started, may contribute to poor outcomes. Is there a need to consider the use of routine USS for presentation only at 36 weeks?	Thank you for this comment. The committee reviewed evidence on routine use of ultrasound to detect breech presentation between 36+0 and 38+6 weeks' gestation. The committee also made a research recommendation for further research on this.
Healthcare Safety Investigation Branch	Guideline	016	011-023	HSIB publications have advocated for the use of tools to support conversations about options in order to inform decision making (Severe_brain_injury_early_neonatal_death_and_intrapartum_stillbirth_with_larger_babies.pdf (hsib.org.uk) Consideration of recommending a structured approach to these conversations is requested.	Thank you for this comment. This was not something that was reviewed by the guideline committee and thus has not been commented on.
Healthcare Safety Investigation Branch	Guideline	019	015	Can this be amended to state: talk "with" the woman not "to" the woman.	Thank you for this comment, we have made the suggested change.

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				This requires strengthening in relation to documented risk assessments to inform place and mode of birth planning to reflect the recommendations of the Ockenden review.	
Healthcare Safety Investigation Branch	Guideline	029	012-016	Consider including reference to ffDNA screening	Thank you for this comment. A reference to the NICE diagnostic guideline on high-throughput non-invasive prenatal testing for fetal RHD genotype was added to the section of the guideline where anti-D prophylaxis is covered.
Healthcare Safety Investigation Branch	Guideline	030	001-006	Consider adding: take into account previous cervical smear test results	Thank you for this comment. The committee did not think this was relevant.
ICP Support	Guideline	022	General	Common Problems in Pregnancy Pruritus (itching) in pregnancy affects 23% of women (1) but for some women it is the only symptom they will have of the most common pregnancy-specific liver condition called intrahepatic cholestasis of pregnancy (ICP) which typically presents in the third trimester of pregnancy, but which can occur as early as 8 weeks of pregnancy (2). It affects around 5,500 women a year in the UK and has an incidence 0f 0.5% with a higher incidence for South Asian women (1.2%).	Thank you for this comment. This was not an area prioritised when the scope for this guideline was developed and has therefore not been covered in this guideline.

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				Adverse outcomes include fetal distress, spontaneous premature birth and in severe cases, stillbirth which has more recently been established to have a risk of 3.44%. Although 90% Of women can be reassured about the safety of their babies, 10% will have severe disease (bile acids over 100m micromol/L) and will need careful monitoring with possible induction around 35 weeks of pregnancy (3). The condition has also been shown to overlap with gestational diabetes (4,5) and pre-eclampsia (6) although the mechanisms for this are not currently fully understood (4,5). Although ICP is not common, as the largest research-based charity for ICP in the world (www.icpsupport.org), we know that women are being refused bile acids tests (the definitive blood test for diagnosing ICP) early in their pregnancies because they are told it is too soon to have ICP, and we are concerned that many women are still not aware that itching (and in ICP the itch can be mild or severe) needs to be flagged up with health professionals. The RCOG is currently updating their Guideline on ICP and we have been involved in this process, but we believe that it is also important that women are made aware of the need to report itching during pregnancy. We suggest that this is something that can be done by health care	

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				professionals within the context of the NICE Antenatal Care Guideline. We do not believe that highlighting itching in pregnancy will unduly increase the workload of health professionals as it is quite straightforward to differentiate the difference between gestational pruritus and ICP, but we do feel that it can help to identify those women whose babies can be better protected by a simple blood test. References: 1 - Kenyon AP, Piercy CN, Girling J, Williamson C, Tribe RM, Shennan AH. Pruritus may precede abnormal liver function tests in pregnant women with obstetric cholestasis: a longitudinal analysis. *BJOG* 2001; 108: 1190–2. https://doi.org/10.1111/j.1471-0528.2003.00281.x 2. Dixon PH, Williamson C. The pathophysiology of intrahepatic cholestasis of pregnancy. *Clin Res Hepatol Gastroenterol* 2016; 40(2): 141–53. https://doi.org/10.1016/j.clinre.2015.12.008. 3. Ovadia C, Seed PT, Sklavounos A, Geenes V, Di Illio C, Chambers J, Kohari K, Bacq Y, Bozkurt N, Brun-Furrer R, Bull L, Estiú MC, Grymowicz M, Gunaydin B, Hague WM, Haslinger C, Hu Y, Kawakita T, Kebapcilar AG, Kebapcilar L, Kondrackienė J, Koster MPH, Kowalska-Kańka A, Kupčinskas L, Lee RH, Locatelli A, Macias RIR, Marschall H-U, Oudijk MA, Raz Y, Rimon E, Shan D, Shao Y, Tribe R, Tripodi V, Abide CY, Yenidede I, Thornton JG, Chappell LC, Williamson C. Association of adverse perinatal outcomes of intrahepatic cholestasis of pregnancy with biochemical markers: results of	

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				aggregate and individual patient data meta-analyses. *The Lancet* 2019; 393(10174): 899–909. https://doi.org/10.1016/S0140-6736(18)31877-4. 4. Martineau M, Raker C, Powrie R, Williamson C. Intrahepatic cholestasis of pregnancy is associated with an increased risk of gestational diabetes. *Eur J Obstet Gynecol Reprod Biol* 2014; 176: 80–5. 5.Majewska A, Godek B, Bomba-Opon D, Wielgos M. Association between intrahepatic cholestasis in pregnancy and gestational diabetes mellitus. A retrospective analysis. *Ginekol Pol* 2019; 90(8): 458–63. https://doi.org/10.5603/GP.2019.0079. 6. Raz Y, Lavie A, Vered Y, Goldiner I, Skornick-Rapaport A, Landsberg Asher Y, Maslovitz S, Levin I, Lessing JB, Kuperminc MJ, Rimon E. Severe intrahepatic cholestasis of pregnancy is a risk factor for preeclampsia in singleton and twin pregnancies. *Am J Obstet Gynecol* 2015; 213: 395–8.	
Kit Tarka Foundation	Guideline	General	General	We are concerned that this guideline does not make reference to reducing infections in newborn babies. The guideline presents an opportunity to remind expectant parents that there are steps they can take to reduce the chances of infection in their babies both antenatally and postnatally. Our main are of concern is reducing herpes infections in babies as the mortality rates in infected babies are so high.	Thank you for this comment and sharing Kit's story. The committee agreed that pregnant women should be given information about infections that might have an impact on the baby, such as herpes simplex virus, cytomegalovirus and group B streptococcus and added this to the list of information to be

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				Kit Tarka Foundation (KTF) was formed after the death of baby Kit from neonatal HSV when he was just 13 days old after contracting HSV postnatally. Kit was treated with antibiotics and, as HSV wasn't suspected until he was dying in an intensive care unit, he never received the antivirals needed to save his life. His story is reflected in many others across the country although most neonatal HSV infections are acquired from the mother during birth. We know from the KTF-funded BPSU study currently underway that HSV infections in babies are on the rise and mortality rates among infected babies are incredibly high. Details of the project and interim results can be seen at kittarkafoundation.org/current-projects. Because some herpes infections do not produce symptoms, the virus can be passed on without anybody realising but there are some simple things parents can do to reduce the risk. We believe parents should be informed of these steps at the earliest stage and reminded throughout pregnancy. This guideline should reflect the RCOG & BASHH guideline 'Management of Genital Herpes in Pregnancy' particularly in the area of prevention.	discussed at the booking appointment (and later if appropriate).
Kit Tarka Foundation	Guideline	018	021	At the first antenatal appointment the woman should be specifically asked about genital herpes infections and the importance of sharing this information should be stressed – including importance of letting midwife know if any symptoms develop during pregnancy. The aim of this will be to	Thank you for this comment. History taking and asking about her health at every appointment should cover this.

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				reduce neonatal herpes which can be fatal or cause long term disability for the baby. It should be stressed that genital herpes is very common and the woman should feel able to discuss openly. If the woman does have a history of genital herpes the RCOG guideline Management of Genital Herpes in pregnancy should be followed. See kittarkafoundation.org/neonatal-herpes-info-and-advice for more information.	
Kit Tarka Foundation	Guideline	018	021	At the first antenatal appointment women who do not have a known history of HSV should be advised to avoid receiving oral sex in their last trimester – especially if their partner has a history of cold sores. See kittarkafoundation.org/neonatal-herpes-info-and-advice for more information.	Thank you for this comment. The recommendations do not include this level of detail, particularly when evidence on the topic has not been reviewed by the guideline committee. However, the committee agreed to add a general point about providing information on infections that might have an impact on the baby, including herpes simplex virus.
Kit Tarka Foundation	Guideline	018	021	At the first antenatal appointment women should be advised to avoid sexual activity in late pregnancy if their partner has active lesions. See kittarkafoundation.org/neonatal-herpes-info-and-advice for more information.	Thank you for this comment. The recommendations do not include this level of detail, particularly when evidence on the topic has not been reviewed by the guideline committee. However, the committee agreed to add a general point about providing information on infections that might have an impact on the baby, including herpes simplex virus.

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Kit Tarka Foundation	Guideline	019	004	Throughout the pregnancy the women should be reminded of the above including asking if they have any signs of a new genital herpes infection. See kittarkafoundation.org/neonatal-herpes-info-and-advice for more information.	Thank you for this comment. The guideline recommends that women are asked about their health and wellbeing and any concerns at every contact so this should be covered. The recommendations are not aiming to provide such detail to include asking about specific conditions.
Kit Tarka Foundation	Guideline	019	020	After 28 weeks information on keeping new babies safe from infection should be given including advice about regular handwashing for parents and visitors before holding the baby and the risks of allowing other people to kiss their baby especially if they have a cold sore. Parents should be advised that should they get a cold sore they should cover and treat with topical acyclovir before holding their baby. It should be noted that the babies of women who have a history of herpes infection are most likely protected against new infections but caution should still be exercised. See kittarkafoundation.org/neonatal-herpes-info-and-advice for more information.	Thank you for this comment. The committee agreed that the guideline cannot include this level of detail, especially on topics they did not review evidence on. However, they did add to the recommendation on what information should be discussed at booking (and later if appropriate) about infections that may impact the baby and how to avoid common infections.
Kit Tarka Foundation	Guideline	019	020	After 28 weeks, women who are planning to breastfeed should be advised that if they develop lesions on their breast or nipples they should stop feeding from that breast immediately and arrange to see their GP as soon as possible. The lesions should be tested for HSV and treated accordingly. See kittarkafoundation.org/neonatal-herpes-info-and-advice for more information.	Thank you for this comment. The committee agreed that the guideline cannot include this level of detail, especially on topics they did not review evidence on. However, the guideline makes reference to the NICE guideline postnatal care which covers planning and management of baby's feeding also during the antenatal care.

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					The postnatal care guideline also covers issues such as asking women about any discomfort or signs of inflammation in their breasts and nipples.
Kit Tarka Foundation	Guideline	020	009	Antenatal classes should cover prevention and recognition of infection in newborn babies	Thank you for this comment which the committee discussed. The topics listed are examples and it is not an exhaustive list. The committee wanted to avoid being to prescriptive.
Kit Tarka Foundation	Guideline	022	007	Interventions for common problems during pregnancy should include a section on suspected herpes infection including importance of HSV testing for any genital sores	Thank you for this comment. This was not included in the scope of this guideline and therefore has not been covered.
Kit Tarka Foundation	Recommendations for research	032	007	Does providing information and advice re prevention of herpes infections in babies lead to a reduction in cases seen in newborns? This should include information on avoidance of receiving oral sex in the last trimester for women with no known HSV infection, avoidance of sexual activity with partners with active herpes lesions, handwashing and 'no kissing' guidance and advice to treat and cover cold sores.	Thank you for this comment. Evidence on information provision on herpes infection or prevention of herpes infections were not reviewed for this guideline and therefore we are not able to make research recommendations on this topic.
LeJeune Clinic	Draft Guideline	024	General	Risk of birth defects.....the word 'risk' is best confined to use around potential death where it could be applied to conditions that people live	Thank you for pointing this out, we have changed the wording.

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		051	020	with happily, such as Down syndrome, the use of this word is inappropriate, Risk of congenital malformations.....	
LeJeune Clinic	Evidence Review A	015	014	'the majority of pregnant women considered midwives the designated caregivers for health education, and considered them reliable sources of important information.' Sadly this is not always the case, particularly in relation to NIPT and to prenatal screening. The Nuffield review commented on the need for this to be improved, the evidence review needs to take this into account. https://www.nuffieldbioethics.org/publications/non-invasive-prenatal-testing	Thank you for this comment. Training of healthcare professionals is generally outside the remit of NICE although guidelines do occasionally comment on the expertise needed to deliver care or a specific intervention. Therefore, this was not a topic that was included in the scope of this guideline.
LeJeune Clinic	Evidence Review A	021	005	All women who are undergoing screening need information on the conditions being screened for to help them make an informed choice about screening. In addition to this, all women who are making decisions about whether to continue or terminate a pregnancy with a condition such as Down syndrome, need information on the care pathway and support they will receive in both of these circumstances. A review of this information should be included here.	Thank you for this comment. The committee has revised the recommendations on screening to make it clear that information about the screening programmes should be discussed and it should be made clear that the woman has the right to decline any part of any of the screening programmes. Providing information about the care pathway after a screening result was not a topic that was included in the scope of this guideline and evidence on it was not reviewed so the committee has not made specific

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					recommendations about it, however, the committee added a recommendation that if there the investigations or examinations find any unexpected findings, referral according to local pathways should be offered and appropriate information provision and support should be ensured.
LeJeune Clinic	Evidence Review B	General	General	'Increased risk of abnormalities' should be replaced by 'increased chance of anomalies' in line with PHE standards. Any use of abnormality elsewhere should also be carefully reviewed for appropriateness.	Thank you for this comment. The use of the words 'increased risk of abnormalities' and other instances of the use 'abnormalities' have been changed to anomalies where appropriate, but not in evidence tables as reported in studies included in the review.
LeJeune Clinic	Evidence Review C	General	General	The use of the words normal and risk should be reviewed here, in line with the poster available at https://phescreening.blog.gov.uk/2019/06/04/language-matters-especially-if-youre-a-health-professional-talking-to-parents-to-be/	Thank you for this comment. The language has been revised according to your suggestion, where appropriate. The use of the word 'risk' is present in evidence tables as reported in studies included in the review.
LeJeune Clinic	Evidence review J	General	General	This review should include reviews by women who have had pregnancies that they have continued, that have had a trisomy, e.g. Down syndrome.	Thank you for this comment. There was no evidence that fit the inclusion criteria for this review that focused on women who have pregnancies they continued that had a trisomy (e.g. Down syndrome) and therefore the committee could not comment on this.
Manchester	Guideline	General	General	Information regarding Chlamydia at booking visit for woman booking under 25 has been removed from the proposed draft guideline	Thank you for this comment. The committee agreed that this recommendation is no longer

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University Foundation Trust					needed and may be unnecessarily stigmatising to young women many of whom are not at risk of having chlamydia. Rather than routinely providing information to all women under 25 years of age about this, the approach should be individualised.
Manchester University Foundation Trust	Guideline	General	General	Information regarding Bacterial vaginosis at booking visit has been removed from the proposed	Thank you for this comment. Information provision about bacterial vaginosis at booking appointment was not included in the old antenatal care guideline either (CG62).
Manchester University Foundation Trust	Guideline	General	General	Screening for asymptomatic bacteriuria has been removed from the booking visit, not sure if that would increase infections in pregnant women.	Thank you for this comment. Consideration of screening for asymptomatic bacteriuria is in the remit of the UK National Screening Committee and it is not currently recommended.
Manchester University Foundation Trust	Guideline	General	General	Woman have been asked to stay at home in this Covid pandemic, whether woman and subsequently baby would benefit if Vitamin D testing and treatment done if deficient. Supplementation will not be adequate to treat a Vitamin D deficiency if it exists.	Thank you for this comment. Vitamin D testing is outside the scope of this guideline, therefore, it has not been considered.
Maternal and Fetal Health	Guideline	1.3.19	022		Thank you for this comment. The committee agreed that practical advice is often sought by pregnant women and while using pillows to

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Research Centre, University of Manchester				We welcome the inclusion of information about avoiding supine going-to-sleep position after 28 weeks' gestation. The example of using pillows however is not based on any studies and women might purchase potentially expensive devices on the basis of this recommendation.	avoid supine position is not based on evidence, it is a simple practical advice that was considered to be helpful. This does not mean women should be encouraged to buy any special devices.
Maternal and Fetal Health Research Centre, University of Manchester	Guideline	1.3.20	022	Given the review of the evidence in section W it would seem appropriate to add the possibility of having a small for gestational age baby to this point. This point should also say "going to sleep" on her back rather than sleeping on her back. Explain to the woman that there may be a link between going to sleep on her back in late pregnancy (after 28 weeks) and stillbirth or having a smaller than expected baby.	Thank you for this comment. The committee discussed at length whether or not to include the increased possibility of small for gestational age to the recommendation and in the end decided to not to in order to keep the recommendation simpler. Stillbirth is the most concerning outcome and adding small for gestational age was not considered to add 'strength' to the recommendation. However, the evidence on small for gestational age is discussed in the 'Why the committee made the recommendations' section. Thank you, we have changed the wording to 'going to sleep' as suggested.
Maternal and Fetal Health Research Centre, University of	Evidence Review W	Table 3	12	The data in the Table are not correct for the Andersen et al. paper. This study only analysed birthweight in live born infants from the individual participant data meta-analysis. In this context the "cases" were women who went to sleep supine (n=57) and those who went to sleep in a non-supine position (n=1703).The description of the study in Appendix D is correct.	Thank you for this comment. This has been corrected.

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Manchester					
Maternal and Fetal Health Research Centre, University of Manchester	Evidence Review P	Appendix K	General	I am concerned that the literature search has not retrieved a series of relevant randomised controlled trials of awareness of fetal movement vs. standard care. These are not included in Appendix K (excluded trials). Delaram, M and Jafarzadeh, L. (2016) 'The effects of fetal movement counting on pregnancy outcomes', Journal of Clinical and Diagnostic Research. Journal of Clinical and Diagnostic Research 10(2). https://www.ncbi.nlm.nih.gov/pmc/?term=10.7860/JCDR/2016/16808.7296[DOI]. Liston, R., Bloom, K. and Zimmer, P. (1994) 'The psychological effects of counting fetal movements.', Birth: Issues in Perinatal Care, 21(3), pp. 135–140. Neldam, S. (1980) 'Fetal movements as an indicator of fetal wellbeing', Lancet 1(8180), pp. 1222–1224. Available at: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med2&NEWS=N&AN=6104039. Inclusion of these studies is unlikely to affect the conclusions drawn by the guideline development group, but these have been included in a systematic review underpinning the forthcoming RCOG guideline for the management of reduced fetal movements.	Thank you for providing these references. They were identified in our literature search and were assessed for inclusion. Delaram 2016 was not included in the review as the study was carried out in Iran, and therefore does not meet the inclusion criteria for country as specified in the protocol. Liston 1994 and Neldam 1980 were not included as they are both outside of the date limit of 2006 as specified in the protocol.

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Maternal and Fetal Health Research Centre, University of Manchester	Evidence Review P	Section 2 Clinical evidence	Page 8	The clinical evidence reviewed here is dominated by the AFFIRM trial (CoI – I was a co-investigator of the AFFIRM trial). It is important to note that AFFIRM differed from the other included studies in that it was not simply a trial of increased maternal awareness, but also included a management plan for women who presented with reduced fetal movements. Therefore, it cannot be included in a meta-analysis of studies that just looked at raising awareness e.g. the Mindfetalness or Grant studies. It is also extremely important to note that the control groups in each other these studies were managed differently as standard care in 1989 was not comparable with that in 2016-2018. I think that if one conducts a meta-analysis of efforts to improve fetal movement awareness (including the studies in Point 4 above and excluding AFFIRM) that the conclusion is that strategies to increase maternal awareness of fetal movements are not associated with a reduction in stillbirth (over and above women's inherent level of concern). The guideline development group correctly emphasise that one cannot infer that women who present with reduced fetal movements should not be screened for fetal compromise, and this is a welcome recommendation.	Thank you. We agree with your comment and agree with the reasons why the included studies were not suitable for a meta-analysis.
Maternal and Fetal Health	Evidence Review P	Appendix J	General		Thank you for this comment. In response to your comments we have added a sensitivity analysis excluding the costs and QALYs incurred from

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Research Centre, University of Manchester				The economic analysis is heavily focussed on the AFFIRM trial. However, as noted above there are some concerns with this approach. AFFIRM had two components i) educating women and staff about the association of stillbirth with reduced fetal movements (RFM) and ii) implementation of a management algorithm for RFM. It is the latter component that was associated with increased costs, rather than the giving of information. The economic analysis makes an assumption that AFFIRM is current "standard care" with the no formal analysis (NFA) being viewed as only undertaken in some units. This is not the case, our studies of local guidelines (Lau et al. BMJ Open Quality, 2020) demonstrate that the majority of units are not even compliant with the NFA approach which is considerably less intensive than AFFIRM. The economic analysis includes differences in delivery mode in the main analysis. Due to the costs involved this is very influential both in terms of costs and QALYs. The authors make the case themselves (on page 51) that mode of delivery is not associated with induction of labour or probability of perinatal mortality. The AFFIRM intervention does not make a recommendation about mode of delivery, only whether IoL. Therefore, delivery mode is unrelated to both the intervention and the outcome and so should not be included in the main economic analysis. Below is a graph of the proportion of births by delivery type as reported by NHS hospitals – it	mode of delivery. We did not feel it was appropriate to remove it from the main analysis given economic evaluations in NICE should try to capture all relevant costs and outcomes to the NHS and PSS and we had some evidence on these parameters from the AFFIRM trial. We think the issues around AFFIRM not covering mode of delivery has been captured in the discussion and considered in the making of recommendations. We have added text around Lau 2020 and AFFIRM not being standard of care in the discussion section of the economic evaluation. We realise there were some limitations with using QALYs in this area including large uncertainty around key inputs such as maternal anxiety. We reflect this is in the sensitivity analyses we perform and in the discussion section where we highlight the limitations of the mode including some discussion about using QALY as an outcome measure. Because of this whilst the economic model seems to strongly favour no formal awareness package the interpretation of the evidence is much softer given these uncertainties. We think both the uncertainties around costs and QALYs have been handled appropriately and equally. Given the larger

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				clearly shows a steady decrease in non-Caesarean births over time (see figure below). There is not a step-change following the introduction of the Saving Babies Lives Care Bundle, suggesting that this trend is not related to the introduction of SBLCB or AFFIRM either. We would argue learning from the SBLCB analysis, delivery costs should not be included in the primary analysis. The tornado diagram in the report clearly shows that the ICER is most greatly affected by the CS risk ratio. This is because there are both costs and QALY losses associated with CS versus vaginal delivery. The one-way sensitivity analysis which excludes maternal anxiety still suggests that NFA is dominant because AFFIRM is associated with a QALY loss – as there are fewer stillbirths under AFFIRM in this analysis (i.e. more QALYs) this suggests that the remaining QALY loss (i.e. that associated with mode of delivery) is still greater than any benefits associated with fewer stillbirths. As AFFIRM does not instruct healthcare professionals to alter mode of delivery (in terms of CS versus VB) we argue that this should not be in the base case analysis. In the discussion the authors make the case themselves that "the relationship between awareness packages and changes in mode of deliveries are not certain".	uncertainties around QALYs they would have wider ranges and more sensitivity analyses assigned to them.The relative risks used in the economic model for perinatal mortality, and elective and emergency caesarean sections are identical to those in the clinical evidence review. How these are calculated is available in the relevant evidence review and methods supplement. Relative risks for the caesarean outcomes were calculated from the raw counts presented in 'Mode of delivery' section of Table 1 in the trial paper and adjusted for the cluster trial design. We were aware of an economic evaluation being conducted and we did have email discussions with the PI as suggested. Whilst the confidential nature of guideline development limited what we could share they were aware of our plans to develop a model covering the same area and of our timelines including around stakeholder consultation.

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				Using QALYs as a measure of health benefit is problematic when the health outcome is perinatal mortality. One issue is that in this analysis the impact on the mother is only included for 1 year, and there is not impact on fathers/partners included which parents who have lost a baby would attest is really not a good reflection of reality. The approach of using average life expectancy and utility values for babies is somewhat inaccurate and so increases uncertainty. Also as is pointed out in the analysis, even health utility derived from the EQ-5D in relation to mode of delivery seems to be counterintuitive - in the source paper there is a greater utility decrement for elective versus emergency CSs for which there isn't really a logical explanation. In addition the utility decrement associated with mother's anxiety after being given a leaflet about RFM is quite large and assumed to be constant for 133 days whereas anxiety tends to fluctuate over time. The authors conclude that uncertainty in relation to costs essentially doesn't matter because in all sensitivity analyses AFFIRM is dominated, but this is because that conclusion is driven by the QALY loss rather than the cost of AFFIRM per se. The authors have not used amended RR for perinatal mortality from the trial paper. It was unclear to me how they calculated the RR for elective and	

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				emergency CS as these were not reported in the paper, they appear to have assumed that in the control phase deliveries which were "other/unspecified" in the Lancet paper were assisted vaginal births (Table 8 in the report (p (AVB)=0.146) versus Table 1 in the Lancet paper (p (AVB)=0.117) We believe that it would be benefit to review this economic analysis with the team who have undertaken a funded piece of work evaluating the AFFIRM study (PI Dr Elizabeth Camacho – University of Manchester).	
Medicines and Healthcare Products Regulatory Agency	Guideline	024-026	Table	Relating to pharmacological treatments for nausea and vomiting in pregnancy, it is not clear that listing the treatments in alphabetical order is the most appropriate way and departs from the usual practice of recommending use of licensed medicines before off-label use. It would be preferable if the order followed licensed use / strength of evidence for safety and efficacy. Also, as noted earlier in section 1.4, nausea and vomiting in pregnancy is likely to resolve before the third trimester, so the value of including information on use during third trimester is unclear.	Thank you for this comment. The committee decided to keep the table in alphabetical order (which is noted in the table). Because the evidence did not clearly show one drug to be more beneficial than others, including the licensed medicine, the committee agreed it is better to be 'neutral' and present the different options in alphabetical order, but present the license and off-label issue clearly in its own column.
Medicines and Healthcare	Guideline	008	004	In addition to being asked about, the woman's history needs to also be recorded into the maternity system to ensure the information is available for subsequent care. The information should be recorded in as structured a	Thank you for this comment. We have now made it explicit that the woman's maternity records should be updated based on information gathered through history taking.

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Products Regulatory Agency				manner as possible to ensure ease of recording, retrieval and analysis for research purposes.	
Medicines and Healthcare Products Regulatory Agency	Guideline	008	013	Include also herbal medicines as these may often be overlooked or not thought of as either a medicine or supplement.	Thank you for this comment. The committee added 'herbal remedies' to the list as suggested.
Medicines and Healthcare Products Regulatory Agency	Guideline	009	025	This section and related entries elsewhere should be expanded regarding patients with any chronic / repeated medication. Aside from the mental health and other conditions highlighted, some chronic medications may need to be continued and/or dose changes may be necessary to maintain maternal health throughout pregnancy. It would therefore be appropriate to include a reminder to refer any patients with any chronic / repeated medication in use to an obstetrician and/or specialist care team for review. The NICE guidance on intrapartum care for women with existing medical conditions does not cover all possible conditions, but such a referral would be in line with this guidance and support decisions on when/whether multidisciplinary care teams are appropriate and support consistency of treatment and advice on care.	Thank you for this comment. The committee has revised the recommendations so that is it clear that if there are medicine considerations, a referral to an obstetrician or a relevant doctor is recommended.
Medicines and Healthca	Guideline	010	008-015	Information on medication use and any changes in this should be sought and recorded at every antenatal appointment. This will give useful	Thank you for this comment. The committee amended the recommendation about recording

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re Products Regulatory Agency				information on care and any underlying conditions but is also important for establishing body of real world data on safety of medicines' use.	and updating the woman's records at every contact to include updates on medication use.
Medicines and Healthcare Products Regulatory Agency	Guideline	038	013	The rationale section for recommendation 1.2.1 does not give the rationale for asking about medication use. This information is vitally important both for clinical care and for research purposes to better understand the impact of medicines used during pregnancy.	Thank you for this comment. We have added some text to the rationale section.
Multiple Births Foundation	Guideline	006	017 - 022	Women with a multiple pregnancy should be referred to nominated multidisciplinary teams of specialist midwives, obstetricians and sonographers to provide the clinical care as recommended in the NICE guideline 137 Twin and triplet pregnancy.	Thank you for this comment. Multiple pregnancy has not been covered by this guideline but the guideline makes a reference to the Twins and triplets guideline. Furthermore, the committee added a recommendation that if anything unexpected/deviation from normal is found in the examinations and investigations (including multiple pregnancy), the women should be referred according to local pathways.
Multiple Births	Guideline	034	General	Although reference to Guideline 137 is included in this section with a list of others relevant to antenatal care, we would like to request the committee	Thank you for this comment. The committee decided not to add this specific detail, however,

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Foundation				to consider a separate sentence saying that as soon as a multiple pregnancy is diagnosed women should be referred to the core team as defined in Guideline 137. Thank you	they added a general recommendation that if anything 'out of the ordinary' is detected in any of the investigations or examinations, women should be referred according to local pathways.
MUTU Holdings Limited	Guideline	019	028	In view of the number of prolapse and incontinence cases requiring specialist physio or surgery when presenting 'too late' to GPs, we recommend the following information is added to - postnatal self-care: 'including (ORCHA approved) guidance on healing and repairing the pelvic floor following birth'	Thank you for this comment. The committee agreed that information on postnatal selfcare should include information pelvic floor exercises but did not add the detail suggested.
MUTU Holdings Limited	Guideline	021	001 - 002	Taking into account cases of prolapse and incontinence cases requiring specialist physio/surgery when presenting to health services 'too late' – we recommend adding to guideline on postnatal care: 'including guidance on healing, repairing and strengthening pelvic floor to avoid later symptoms that are distressing and may require secondary care intervention including surgery'	Thank you for this comment which the committee discussed. The topics listed are examples and it is not an exhaustive list. The committee wanted to avoid being to prescriptive. Pelvic floor exercises have been added to the recommendation about what information should be provided and discussed at appointments after 28 weeks.
MUTU Holdings Limited	Guideline	047	004 - 006	Re: 'signposting to trusted resources may be helpful' – we suggest signposting to ORCHA and NHS DAQ assessment approved resources.	Thank you for this comment. The committee decided not include references to any particular

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					resources because these were not reviewed by the committee or accredited by NICE.
NHS England and NHS Improvement	Guideline	General	General	Screening and immunisation programmes seem to have been largely overlooked in this revision of the guideline (PHC)	Thank you for this comment. Screening and immunisation programmes are covered by the UK National Screening Committee and the Joint Committee on Vaccination and Immunisation, respectively, therefore these have not been reviewed separately. However, signposting to the national screening and immunisation programmes have been made and some revisions to the recommendations have been made to ensure appropriate information provision and discussion about screening programmes to enable informed decision making. A reference to covid-19 vaccination was also added to the recommendation about providing information about immunisations.
NHS England and NHS Improvement	Guideline	General	General	Antenatal and newborn screening has developed considerably since the guideline was first published in 2008; screening is hardly mentioned in the updated guideline and this feels like a missed opportunity (PHC)	Thank you for this comment. Screening and immunisation programmes are covered by the UK National Screening Committee, therefore these have not been reviewed separately. However, signposting to the national screening programmes have been made and the recommendations have been revised to ensure appropriate information provision and discussion about screening programmes to enable informed decision making. The committee have also added

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					newborn screening tests to be discussed at the third trimester antenatal appointments.
NHS England and NHS Improvement	Guideline	General	General	Taking the AN history – a universal checklist would be helpful – otherwise every local maternity service will invent its own leading to untoward variations - (PHC)	Thank you for this comment. The guideline lists various topics that should be asked and discussed as part of history taking, however, the committee agreed that a universal checklist may risk history taking becoming a tick box exercise rather than an individualised discussion. Evidence on what the content of such a checklist should be was not explicitly reviewed either so the committee agreed not to create such a checklist. However, your comment will be considered by NICE where relevant support activity is being planned.
NHS England and NHS Improvement	Guideline	006	012	section 1.1.7 Suggestion to rephrase "appointment with midwife or doctor". Presumably the term "doctor" here refers to a doctor in the obstetric team, as opposed to the GP. This term should have greater clarity to reduce possibility of confusion (EN)	Thank you for this comment. The committee agreed to say 'doctor' because in some areas and cases a GP might carry out an antenatal care appointment.
NHS England and NHS Improvement	Guideline	006	015	section 1.1.7 Suggestion to rephrase "appointment with midwife or doctor". Presumably the term "doctor" here refers to a doctor in the obstetric team, as opposed to the GP. This term should have greater clarity to reduce possibility of confusion (EN)	Thank you for this comment. The committee agreed to say 'doctor' because in some areas and cases a GP might carry out an antenatal care appointment.
NHS England and NHS	Guideline	006	045	There is currently no mention of the importance of maintaining antenatal care provision when a women moves area / transfers to another hospital. This is likely to be due there being no robust evidence on this subject but	Thank you for this comment. Based on stakeholder feedback, the committee agreed to add a recommendation which states that there

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Improvement				we know that this can lead to women 'slipping through the net' and missing aspects of their antenatal care as a result. Could this maybe be considered as an area of research recommendation or a statement acknowledging the issue being considered? (DR)	needs to be effective and prompt communication between healthcare professionals who are involved in the care of the pregnant woman, this includes also women who move area and their provider.
NHS England and NHS Improvement	Guideline	007	006-007	Link to Visitors Guidance (re. Covid restrictions)	Thank you for this comment. We have not made a reference to any specific COVID guidance as these will likely change within relatively short timeframe.
NHS England and NHS Improvement	Guideline	008	General	There is no mention of immunisation status & advice, such as determining MMR/Rubella status at booking; discussion of pertussis and flu vaccination; or assessment antenatally of a neonate's eligibility for BCG, which will be important in the context of the SCID evaluative screening project (PHC)	Thank you for this comment which the committee discussed. Information around relevant immunisations should be discussed at booking appointment and this is covered by the section on information about antenatal care. In relation to history taking, the committee agreed that there is no need to specify asking about the woman's immunisation status because this will not impact her antenatal care.
NHS England and NHS Improvement	Guideline	008	005	there is no mention of recording diabetes status as part of the woman's history so she can be referred to diabetic eye screening (PHC)	Thank you for this comment. Taking her medical history should cover this.
NHS England and NHS	Guideline	008	005	Consider : asking if maternal mother had history of breech presentation Consider : question on close relative marriage (consanguinity)	Thank you for this comment. The committee did not consider these to be relevant or even appropriate questions for routine history taking.

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Improvement					For example, consanguinity would only potentially become a relevant issue if some abnormalities are detected in the fetal anomaly screening.
NHS England and NHS Improvement	Guideline	009	016-019	Addressing the wider determinants of health therefore consider: • Support efforts to reduce and mitigate against poverty (the most important determinant of a child's health) • Housing - focus on the private-rented sector to ensure that housing is safe and warm and meets basic standards for mother and baby • Identify and address inappropriate environments • Working with Homeless Families Services to support vulnerable pregnant mothers (DR)	Thank you for this comment. Evidence on this was not reviewed so no recommendations have been made, however, the committee absolutely agrees that this issue will require addressing the wider determinants of health and have noted this in the 'Why the committee made the recommendations' section.
NHS England and NHS Improvement	Guideline	010	020	Add ' and record ' (DR)	Thank you for this comment. We have not included this here because another recommendation in the guideline covers it, stating that the woman's records should be updated with any test results, examination findings, history and so on.
NHS England and NHS Improvement	Guideline	011	001	Section 1.2.12 links to the antenatal screening programmes but there is no reference to fast-tracking those who have previously screened positive, for example Sickle Cell and Thalassaemia carrier couples (PHC)	Thank you for this comment. This information should be captured in history taking and appropriate action taken based on that. The committee agreed not to include this level of detail in the recommendations.

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NHS England and NHS Improvement	Guideline	015	011	Section 1.2.33 regarding breech presentation does not include any information about this being a NIPE hip screening risk factor (PHC)	Thank you for this comment. Discussion about benefits, harms and implications for the options will cover this.
NHS England and NHS Improvement	Guideline	018	004	does not mention providing the 'Screening Tests for You and Your Baby' digital information/or booklet to the woman as part of the information about antenatal care Does not mention information about BCG vaccination for baby if eligible (PHC)	Thank you for this comment. The committee has added screening programmes to the list of topics to discuss. Discussion around newborn screening have been added to another recommendation covering discussion points later in pregnancy.
NHS England and NHS Improvement	Guideline	019	020	Section 1.3.11 does not mention any of the newborn screening tests within the discussion about the postnatal period. It does not mention the need for neonatal BCG if eligible (PHC)	Thank you for this comment, newborn screening has been added to the list.
NHS England and NHS Improvement	Guideline	030	007	More specific advice required for GPs to refer for unexplained vaginal bleeding after 13 weeks, and then placental localisation by ultrasound if placental site is not known (EN)	Thank you for this comment. The committee agreed to add a recommendation which clearly states that all women with unexplained vaginal bleeding after 13 weeks should be referred to secondary care for a review.
NICE - Quality standards and	General	General	General	GE minutes for the 02/02/21 on the update of Antenatal care for uncomplicated pregnancies guideline note that development of the fetal alcohol spectrum disorder (FASD) quality standard (QS) may impact on the	Thank you for providing comments on the draft guideline.

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indicators				draft recommendations. There was an action for comments to be fed back through the consultation.	
NICE - Quality standards and indicators	Guideline	General		Recommendations in CG62 are used as an evidence source for statements 1-4, 6, and 8-12 inclusive in the antenatal care quality standard (QS22). The guideline is also an evidence source in the following quality standards: hypertension in pregnancy (QS35, statement 2), maternal and child nutrition (QS98, statement 1) and intrapartum care (QS105, statement 1). Evidence sources and definitions will be updated to reflect changes to recommendations throughout these quality statements.	Thank you for this comment.
NICE - Quality standards and indicators	Guideline	General	General	QS22 statement 4, which refers to women with a BMI of 30 kg/m2 and over at the booking appointment being offered personalised advice is currently supported by evidence sources including CG62 recommendations 1.5.1.1 and 1.2.2.2. We may need to amend the statement wording to reflect the wording in draft recommendation 1.2.1.1 in the updated guideline as this states that the BMI should be calculated at the first face-to-face antenatal appointment rather than at the booking appointment.	Thank you for this comment. The first face-to-face appointment is very likely the booking appointment but, however, in rare cases (and particularly during a pandemic) this might be done virtually.
NICE - Quality standards and indicators	Guideline	General	General	QS22 Statements 8 and 9 focus on referral for specialist advice/care for women identified as at intermediate and high risk (respectively) of VTE at the booking appointment. The statements currently use CG62 recommendation 1.2.2.2 and the RCOG Green-top Guideline no 37a as source guidance. The removal of recommendation 1.2.2.2 and inclusion of	Thank you for this comment. Please be aware that the wording in the recommendation you're referring to has been amended after consultation.

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				draft recommendation 1.2.17 on considering referral to an obstetrician for women at risk of VTE may affect the statement wording.	
NICE - Quality standards and indicators	Guideline	Guideline	Guideline	Current practice in antenatal care includes recording information on alcohol consumption. For example, the NHS digital Maternity Services Data Set includes information on alcohol consumption recorded at the antenatal booking appointment; and the Perinatal Institute Pregnancy notes record information on alcohol consumption in pregnancy. However, there is variation in practice. For example, in 2017, 57% of records in the Maternity Services Dataset had information on the number of units of alcohol drunk in the week before the antenatal booking. The new antenatal guideline could help address variation in practice by making explicit reference to recording information on alcohol consumption in pregnancy.	Thank you for this comment. The recommendation on history taking includes asking about alcohol consumption and the recommendation about updating the woman's records at every antenatal appointment has been revised to include "details of history" to make it clear that the history taking should be recorded.
NICE - Quality standards and indicators	Guideline	005-0034	009-012 015-021	Draft recommendation 1.1.2 says "At the point of referral, provide early pregnancy information..". It would be helpful if this recommendation stated what this information could or should include. CG62 recommendation 1.1.1.1 currently provides bullet points of information that should be included at first contact. The rationale for the draft guideline (page 34) says that committee agreed that the referral contact should include provision of early pregnancy information, for example, public health messages and that it is also important to identify women with specific needs or risk factors early on so	Thank you for this comment. The committee agreed to add some examples to the recommendation, including smoking cessation and alcohol consumption.

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				that appropriate care can be provided from the beginning. This could be expanded on and examples included in the recommendation. The lack of detail on what early pregnancy information is makes it difficult to determine if this would now be a recommendation that FASD statement 1 could be based on. CG62 recommendation 1.1.1.1 said information at first contact should include 'lifestyle advice, including smoking cessation, and the implications of recreational drug use and alcohol consumption in pregnancy'. It is not clear in the draft guideline if this is early pregnancy information, or if this information would only be given at the booking appointment as per recommendation 1.3.7.	
NICE - Quality standards and indicators	Guideline	005-006	013 001-004	Draft recommendation 1.1.3 says the referral form for starting antenatal care should enable healthcare professionals to identify women with "…risk factors including those that can potentially be reduced, for example, smoking". It would be helpful to include consuming alcohol as an example for this recommendation.	Thank you for this comment. The committee decided not to add more examples to the recommendation, however, they added examples of early pregnancy information that should be provided, including alcohol consumption and made a cross reference to the UK Chief Medical Officer's low-risk drinking guidelines.
NICE - Quality standards and indicators	Guideline	06	13	We note that there is a link in the draft guideline to a 'schedule of appointments' but this document has not been made available for review. QS35 statement 2 and QS22 statements 1 and 3 refer to the 'Appointment schedule' (Appendix D) in the current guideline (CG62). QS22 statement 3 presents information from Appendix D as a table in the definitions section.	Thank you for this information. The 'schedule of appointments' is based on the final version of the guideline and is published at the same time as the guideline.

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				Any changes to the schedule of appointments will need to be reflected in the relevant QSs.	
NICE - Quality standards and indicators	Guideline	007	001-002	QS22 statement 2 concerns pregnant women being cared for by a named midwife. The statement focused on this role following consultation and committee discussion. Focusing on a single role improved measurability and aligned with key aspects of national policy.	Thank you for this comment. The guideline recommends that those planning and delivering antenatal care should aim to provide continuity of carer. Continuity of carer is defined in the 'Terms used in this guideline' section, and usually means a team of midwives with one midwife coordinating the care. The original guideline (CG62) does not recommend a named midwife either.
NICE - Quality standards and indicators	Guideline	008	003-020	There is no explicit reference to recording information on alcohol consumption at antenatal appointments or during pregnancy. Recommendation 1.2.1 seems to imply that the information the woman is asked about is recorded but it would be helpful to make this explicit. Lines 18-19 say 'factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use'. It would be helpful to have more clarity on what is being asked for here. For example, is it a general history of alcohol consumption before pregnancy, is it the amount drunk in the last week, is it the estimated number of units consumed since becoming pregnant etc. Statement 2 of the draft FASD QS says 'Pregnant women have information on their alcohol consumption recorded throughout their pregnancy'. It is	Thank you for this comment. We have now made it explicit that the woman's maternity records should be updated based on information gathered through history taking.

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				based on SIGN 156 recommendations 2.1 (page 11) and 2.1.2 (page 12). It is also based on NICE guideline PH4 Alcohol-use disorders: prevention recommendation 9. CG62 has not been used as a source due to being unable to find recommendation that could be used as an appropriate base for the statement. It would help the development of the QS to be able to link to a recommendation in the new antenatal care guideline. Making reference to recording information on alcohol consumption at antenatal appointments would also help ensure the updated guideline aligns with PH4 recommendation 9 which says: "NHS professionals should routinely carry out alcohol screening as an integral part of practice". As an example, it adds these discussions should also take place "...when seeing someone for an antenatal appointment".	
NICE - Quality standards and indicators	Guideline	010	016-017	QS22 statement 3 concerns women having all of the minimum set of antenatal test results in their hand-held maternity notes and uses CG62 rec 1.2.4.2 as source guidance. Draft recommendation 1.2.10 does not refer to hand-held case notes so the statement wording may need to be amended. The statement also cites CG110 recommendation 1.1.10 as an evidence source, which refers to hand-held case notes.	Thank you for this comment. We agree that the QS statement might need amending.
NICE - Quality standards and	Guideline	018	026-029	Current CG62 recommendation 1.1.1.1 is the source for statement 1 in the draft FASD QS. Statement 1: 'Pregnant women are given advice not to drink alcohol during pregnancy at their first contact appointment'. Draft guideline recommendation 1.3.7 appears to be the closest equivalent	Thank you for this comment. The committee has added "avoiding alcohol" as one of the key early pregnancy information that should be provided

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indicators				recommendation to base the statement on, but it has differences in terms of timing and content. Timing CG62 1.1.1.1 says at "…the first contact with a healthcare professional" information should be given on …lifestyle advice, including smoking cessation, and the implications of recreational drug use and alcohol consumption in pregnancy". Draft recommendation 1.3.7 shifts the timing of providing this advice to the booking appointment. Timing of giving advice and information on alcohol consumption was discussed by QSAC who agreed that it should be as early as possible, i.e. at first contact rather than at the booking appointment. This means that the draft QS does not align with the draft guideline recommendation with respect to timing. Content Draft recommendation 1.3.7 does not say what should be discussed about alcohol, and what information should be given. Instead, it provides a link to the UK CMO guidelines. The need to avoid repetition in the NICE guideline is understood, but in this case it would be helpful to include this key message.	when woman is initially referred to antenatal care.

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				Information submitted at topic engagement for the FASD QS, and discussion at QSAC in December 2019, indicated that awareness of the CMO guidelines was lacking amongst some midwives and the public. There was also confusion and misunderstanding about the message.	
NICE - Quality standards and indicators	Guideline	19	15	QS105 statement 1 uses CG62 recommendation 1.1.1.1 as an evidence source and concerns women being given the choice of all 4 birth settings and information about local birth outcomes. A quality measure refers to this discussion taking place at the booking appointment, which is consistent with the current underpinning recommendation. Draft recommendation 1.3.10 however states that discussion of birth preferences takes place before 28 weeks. This amended timeframe will make it more challenging for services to measure achievement against the statement because it is not clear at what point before 28 weeks is the optimum timeframe or if it is acceptable to have the discussion at the 28 week appointment. The process measures for statement 1 in QS105 will need to be amended or may be removed as a result of this new timeframe.	Thank you for this comment. The committee agreed that the guidance should not be too prescriptive about the timing of all the discussions and the initiation of the discussion around birth preferences might depend on the individual woman's needs and preferences. This flexibility and individualisation seems to be also something that other stakeholders valued. The quality standard on this particular issue may therefore need to be reviewed.
NSPCC	Evidence Review A	018	008-025	The rationale stated in this section is concerning as it does not consider in any depth the following: There is currently an increasing focus on neuroscience, particularly brain development, in the early years of life; the first 1001 days of life, conception to age 2, is a time of unique opportunity and vulnerability and a period of particularly rapid growth, when the foundations for later development are	Thank you for this comment. The committee discussed the importance of bonding and attachment with the baby during the antenatal period. The guideline recommends discussing the issues of bonding and emotional attachment with expectant parents during pregnancy during appointments and classes. The NICE guideline on postnatal care covers issues related to emotional attachment and bonding, including how some

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				laid. During this time, babies' brains are shaped by the interactions they have with their parents and the world. There is compelling evidence to show that early relationships play an extremely important role in cognitive, emotional and social development and if these early relationships are compromised it can have a pervasive effect on physical and emotional health. This impacts children and young people's mental health and has long-term costs to individuals, but to families, communities and society. The quality of the parent-infant interactions therefore is important for infant mental health. Blackpool, through the Better Start initiative, is taking a place-based approach to reducing the critical stressors experienced by families and increasing their capacity and capabilities. Where there are unresolved parent-infant relationship difficulties this can be passed on to future generations of parents leading to inter-generational distress and additional high costs to the public purse. As a result, there is a need for early intervention to prevent or intervene early. Through BBS the town is collectively supporting infant mental health which will have an impact on later child outcomes and the same is true for the NSPCC. Parents' representations of their babies, both before and after birth, are important predictors of their bonding with their babies and are linked with the child's later attachment to their parents. Most of the research in this space relates to mothers. Between the fourth and seventh month of	parents may need additional support in bonding with their babies, and we have referred to that section in the postnatal care guideline in the antenatal care guideline.

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				gestation, mums develop internal representations about the baby-to-be (i.e. feelings about what the foetus is like) (Stern 1985). These are shaped not only by the biological changes taking place but also by psychic and social factors such as the mother's memories of her own early relationships, her family traditions, her hopes, her fears and her fantasies. The richness of mums' antenatal representations has been significantly linked with the security of the infants' attachment to their parents at one year of age (Benoit, Parker & Zeanah 1995). Research has highlighted that certain situations may put a woman at greater risk of developing negative representations of her unborn infant – for example, if she is in a situation where there is domestic abuse, or if she has an unplanned pregnancy when she already has two or three children under seven years (Huth- Bocks et al. 2004; Pajulo et al. 2001) Raphael-Leff (2001). cautions that representations that are 'laden with excessive fears' or even with 'idealised expectations about their imagined baby', can interfere with the process of establishing a relationship with the 'real' baby.' Helping parents to imagine what their baby may be like as an individual, and their characteristics, and likes or dislikes, during pregnancy helps parents to develop an emotional connection with their baby. Once the baby is perceived as a real person, parents are more likely to make health-promoting choices, such as giving up smoking or alcohol.	

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				Mothers who have had a past neonatal loss may be too distressed to engage with their new baby because they fear experiencing the pain of loss again. These mothers will need to be treated with great sensitivity and may need to access specialist help to manage these powerful feelings before they can engage with their new baby. Specialist perinatal psychologists are available in some areas and bereavement counsellors can be accessed through voluntary sector groups.	
NSPCC	Guideline	General	General	The role of health visitor and communication in the guide: More emphasis/inclusion within the guideline on the role of the health visitor in antenatal care and the importance of communication between midwifery and health visiting in relation to antenatal care. There is a mandated antenatal visit by health visitors from 28 weeks of pregnancy onwards. Health visitors play a key role in delivering antenatal education. Health visitors can reinforce many of the messages that are provided as part of antenatal care and provide the earliest intervention. In Blackpool midwives and health visitors work closely to deliver Baby Steps the universal perinatal programme. The antenatal period offer opportunity for parents to reflect on what kind of parents they wish to be and it is also a time they consider the way they were parented.	Thank you for this comment which the committee discussed. The role of the health visitor was not included in the scope of this guideline and was therefore not covered by the evidence reviews and not commented on. However, the committee decided to add a recommendation based on stakeholder feedback about effective and prompt communication between healthcare providers who are involved in the woman's care during pregnancy. The committee also revised some of the recommendations to include more consideration around previous trauma.

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				In Blackpool (CECD) additional assessment tools have been introduced enabling the service to be better tailored to the needs of local families. HVs now explore parents' own experiences of adverse childhood experiences (ACEs) and trauma at the antenatal contact. This supports the health visitor's relationship with parents and enables parents to think about how to reduce their unborn child's exposure to ACEs and build their resilience. Emphasis is needed within the guidelines about incorporating a trauma informed approach to antenatal care. The CECD has developed an innovative suite of trauma focused interventions alongside more widespread trauma awareness training and community education approaches. It is therefore developing trauma informed systems which support and enhance the specific programmes being provided and ensure a consistent and seamless journey through services for families. This will ensure that there is extensive understanding of the importance of trauma and early adversity from all parts of society and community. Together the workforce and community will influence systems and culture change and reduce the stigma and taboo surrounding trauma and adversity.	
NSPCC	Guideline	General	General	Greater recognition for the role of Trauma Informed Care throughout the whole journey for expectant paretns is needed throughout the guide.	Thank you for this comment. Trauma informed care was not included in the scope of this guideline and evidence on it in the context of

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				Dr Lauren Wolfenden and Clare Law were commissioned by NHS E/I to produce good practice guidance for Trauma Informed Care in the perinatal period for perinatal mental health and maternity services staff. The guidelines have been produced for all staff involved in the care of women and their partners during and after pregnancy. This includes: all staff, from doctors and nurses through to the reception team and portage. Importantly, it is also for women and men who receive care from services during and after pregnancy. Key findings include: Changes to care and birth planning – staff can empower the mother without an agenda. Women and men felt as though staff needed: awareness of previous trauma and mental health difficulties; compassion when birth preferences change; and to communicate with sensitivity and kindness. Language used from staff was viewed as integral to the care experience, and informed choice, control and decision making. Supportive, compassionate and empathetic language and being-kind, strengthened communication and prevented miscommunication. Continuity of carer and being able to build a relationship the their care provider impacted parents' mental health and ability to open up. This was also linked with mental health support from early pregnancy, and early identification and signposting to services throughout pregnancy. This was	antenatal care was therefore not reviewed or commented on. However, over all the recommendations for example about communication with women emphasise that the discussions should be individualised, sensitive, supportive and respectful. The guideline also comments that antenatal care services should aim to provide continuity of carer. Based on your and other stakeholders' feedback, the committee revised the guideline to add some more consideration to previous trauma, for example, that at every antenatal appointment healthcare providers should provide a safe environment and opportunities for the woman to discuss topics they want to discuss, including previous trauma.

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				also integral for dads/partners as they often felt invisible and useless. Frequently it was reported that "Communication is key to prevent mental health deterioration" and for both women and men, they felt as though staff can "prevent me from experiencing unnecessary crisis" – this was incredibly important for those with pre-existing poor mental health or trauma, as appropriate support allowed informed decision making and prevented individuals from re-living their trauma (e.g., PTSD symptoms) or being re-traumatised in services. Knowing their rights facilitated safety. When communication was poor, individuals could not make informed decisions and there was no continuity of carer, attendance in services, and a decline in mental health or re-living their trauma was reported. This was also reported postnatally. A wide NHS staff survey we conducted with almost 500 staff memebrs showed that the majority (74%) of Staff within the survey felt as though they needed to gain more knowledge about trauma and needed more time to reflect on the work and the impact of trauma on themselves (72%). Over half reported that they felt like change to processes, modelling of trauma informed care by leadership and more opportunities for peer support was needed.	

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				We hope that this will make a difference to women and their partners and to staff. It can create a common language, shared decision-making, safety and feelings of empowerment. When services begin their journey to becoming trauma informed and integrating trauma informed approaches within their service, the four key principles will help guide each interaction and conversation with service users. It will also support staff to recognise their own needs and trauma experiences. Principle 1 - Recognition and compassion Principle 2 - Communication and collaboration Principle 3 - Consistency and continuity Principle 4 - Recognising diversity and facilitating recovery For staff within organisations, we hope they can use the tools we have provided to begin the process of becoming a trauma-informed system, and truly make use of the practical tips shared in the implementation tables. Describing this approach and recognising the importance of being more trauma aware and informed in maternity services is essential to provide the best possible care for expectant parents and protect staff from secondary or vicarious trauma and burn out.	

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NSPCC	Guideline	General	General	The guide needs to be more informed in the understanding of the connection between psychological and physical health, particularly so in pregnancy. Psychological approaches to diet and nutrition in perinatal period: The evidence indicates that nationally, there has been an increase in the number of women who are overweight or obese pre-conception. Currently in the UK approximately 1-in-5 pregnancies fall into the 'obese' category (Heslehurst et al., 2010), and it is projected to continue to increase due to a higher number of obese teenagers reaching child rearing age. Being overweight during pregnancy and gaining further excessive weight during this period can lead to a range of poor maternal and child outcomes. Women with a high BMI during pregnancy are at greater risk of a series of physical and foetal health complications (Sebire et al., 2001). High levels of psychological stress can occur for all women during pregnancy; however, those who are obese are reported to experience considerably more psychological stress, poor self-image, low self-esteem and greater emotional challenges than those within a normal weight range (Molyneaux et al., 2014; Holton et al., 2019). Evidence has demonstrated that there is an association between pregnancy-related maternal depression and obesity, poor socioeconomic status, lack of social support, history of domestic violence or abuse, trauma and adverse	Thank you for this comment. The guideline aims to provide a holistic approach to antenatal care where all aspects of health and wellbeing, including physical, emotional and social aspects are considered and responded to. The guideline also recommends discussions around diet and nutrition from early on. Based on stakeholder feedback, the committee added that early pregnancy information provided when the woman is first referred to antenatal care should include information on healthy eating.

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				life events, high stress and history of mental health problems (Lancaster et al., 2010; Molyneaux et al., 2014; Biaggi et al., 2016). Many studies have shown that those who are less satisfied with their body shape or image are less likely to breastfeed and are more likely to experience depression or psychological distress. This can be a vicious cycle that can also lead to eating disorders postpartum. For women who are obese during pregnancy there is a greater likelihood of antenatal depression, postnatal depression, and antenatal anxiety and were less likely to initiate breastfeeding (Olander et al., 2011). In longitudinal analyses of these women evidence suggests that women are 67% more likely to be experiencing depression at follow-up appointments compared to women of a normal or healthy weight (Luppino et al., 2010). Ensuring that women and their partners are supported to develop realistic views and understanding of the changes to weight, body shape and the appearance of skin, breasts and abdominal region could prevent the worsening of mental health postnatally, especially for those who are overweight or obese pre-conception. This is of particular importance due to the current influence of social media and celebrity culture on women's sense of self, ideals and expectations. Integration of body shape changes to the antenatal parenting programme could also ensure that women of all shapes and sizes pre-conception can be prepared and are truthfully informed about what will change and may help answer questions about regaining a similar physique or shape postnatally.	

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				Antenatal clinical care and antenatal classes provide the prime opportunity to educate and support parents to improve their own diet and nutrition during the perinatal period, but also that of their baby. In Blackpool an additional training session has been offered to Baby Steps facilitators in order to support greater understanding of core diet and nutrition messages, particularly from a psychological and more trauma informed perspective. This is currently evaluated but initial findings are encouraging that this addition is of value and having a psychological approach to diet and nutrition messages within antenatal education is worthy of consideration in this guideline.	
NSPCC	Guideline	007	013-014	It is essential that the partner is not given information for just providing support during the pregnancy. It is crucial that partners are informed about how to provide support postnatally too. Proving this information early can allow couples/families and individuals to prepare, especially if there are known mental health difficulties or previous social and emotional difficulties from either the pregnant woman or their partner.	Thank you for this comment. The committee has revised the recommendation to say "during and after pregnancy". Similar revision was made in the section on what should be covered in antenatal classes. Thank you for providing a reference to the NHS E/I guide to trauma informed care for staff in perinatal mental health and maternity services, which did not appear in our search results as it did not match the protocol's inclusion criteria and therefore cannot be included in the review for the committee to comment on.

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				This can mean services are able to either provide support early or individuals know of the support readily available should it be needed during the pregnancy or postnatally. During the development of our NHS E/I guide to trauma informed care for staff in perinatal mental health and maternity services (https://www.england.nhs.uk/wp-content/uploads/2021/02/A-good-practice-guide-to-support-implementation-of-trauma-informed-care-in-the-perinatal-period-February-2021.pdf) partners voices were heard and the need for information as soon as possible was highlighted. Being informed early on in pregnancy affords the partner with an opportunity to feel "less invisible" and more involved, particularly in the later stages of pregnancy and birth.	
NSPCC	Guideline	007	008	There is evidence to indicate that partners feel more involved if: • It is explained to partners that antenatal classes are for both parents, and that they will have a chance to discuss their own roles, concerns and experiences with other partners • Emphasis is placed to both parents the important role that partners can play for mums and babies	Thank you for this comment. There was good quality evidence on partners' views and experiences of antenatal care that showed that women appreciate being able to involve their partners in antenatal care and therefore the committee made recommendations based on this and their own knowledge and experience. However, the committee were clear that

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				• Partners are engaged directly, using their name and enquiring about how they are doing • Ensuring partners feel involved in conversations during group sessions • Addressing letters and invitations to both parents, and contacting partners directly • Making sure what is said in group sessions works for both parents Furthermore, evidence indicates that a woman whose partner remains involved during pregnancy is more likely to; attend antenatal care, take better care of her own health, deliver a healthy baby and recover more quickly from postnatal depression (Fletcher, May and St. George, 2014; Fatherhood Institute, 2010). Antenatal contacts where partners/dads are present also provide an opportunity for mental health checks for dads. NHS England and Improvement however have made some steps in including mental health checks for dads during the perinatal period in instances where the mother has poor mental health. This recognises the important role of dads in supporting the mother and potential impact of the partner's mental health on themselves. However, routine checks taking place for *all* dads are required (Baldwin et al., 2019). Additionally, whilst the desire from frontline staff to ask dad about his mental health or experiences of trauma may be there, the systems are not in place to support this and can result in	partner's involvement should be always based on the wishes of the woman. Given this premise, the guideline makes it clear that the discussions at appointments should be had with the woman and her partner (if present and if the woman wants). The mental health or experiences of trauma of the woman's partner was not within the remit of this guideline and therefore no evidence was identified for the committee to comment on. However, the committee revised the recommendations on history taking to include asking about any issues, for example illness or substance use problems, related to her partner or other family members that might impact her wellbeing.

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				practitioners being unable to record and provide support. This warrants further investment and this guideline could acknowledge this.	
NSPCC	Guideline	007	021	There is evidence from the recent NSPCC (2021) *Learning from Adapting the Baby Steps Programme in Response to COVID-!9* report which found the benefits of virtual attendance at antenatal programmes. Enhanced collaboration, sharing and support across agencies was seen when a virtual/blended model with the creation and use of innovative tech based solutions was adopted for delivering perinatal education programme during COVID-19. This method of delivery encouraged increased access and reach across the geography, partners and undeserved groups. In addition to this, in Blackpool (work through the CECD), family engagement workers who are part of the Baby Steps delivery team (NSPCC staff) undertook weekly telephone calls with expectant parents. These would previously have been face-to-face and in a group session, however this model meant that they can tailor specific sessions and provide an enhanced and individual service.	Thank you for this comment. Virtual appointments was not included in the scope of this guideline, the scope was developed in 2019. Virtual approaches to antenatal care have of course become much more prominent in recent times and evidence on their benefits and harms continue to emerge in the future. However, this type of evidence was not reviewed by the committee and is therefore not commented on apart from recommending considering supporting partner involvement via remote attendance, taking into consideration any inequalities consideration that may rise from that. We will pass your comment about virtual appointments to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				In addition, the team have noticed an increase in uptake in the programme and increased participation from dads and partners. Whilst the reasons for this are potentially multi-faceted, including parents feeling more anxious and in need of support services, there is also anecdotal feedback which suggests that this more tailored and flexible approach is more accessible for parents. There has also been work with NSPCC nationally on the development of online materials which means that parents can also access and then digest key messages in their own time, no longer restricted by group dates and times. A study regarding online perinatal mental health service delivery has shown that women often find perinatal services difficult to engage with due to child care, napping schedules and transport (O'Mahen, 2013). This could also be true for antenatal education programmes where parents are often juggling other children and responsibilities. Services like Baby Steps, whether virtual or face-to-face, can provide the ingredients to support new parents to respond to their baby's needs, see the world through their eyes and build secure relationships from which they can develop and thrive.	
NSPCC	Guideline	008	006	We are concerned that this guideline is not explicit in recommending that at the booking and each subsequent routine antenatal clinical care	Thank you for this comment. We think that this is covered in the guideline although the committee did not want to be prescriptive in terms of exactly how and when this issue should

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				appointment that women and their partners are asked about their relationship with their baby. It is noted that reference is made to NICE CG 192 where there is mention of enquiring about the 'mother-baby relationship.' This is not enough. There is clear and compelling evidence on the importance that each baby has at least one loving, sensitive and nurturing relationship in the first 1001 days as this is a critical foundation for a healthy and fulfilling life (Parent Infant Foundation, 2021).	be discussed. There is a recommendation in the guideline that says that throughout pregnancy bonding and emotional attachment should be discussed and given information on, and a reference to the section on postnatal care guideline which covers bonding and emotional attachment (also covering the antenatal period). We have revised the recommendation to refer to 'baby' and not 'newborn baby' because the committee agrees this also includes the unborn baby. Furthermore, the guideline recommends that antenatal classes should also cover issues around bonding and emotional attachment.
NSPCC	Guideline	008	018	The evidence is clear about the importance of diet and nutrition in pregnancy and more could be included on this in the guideline. The proportion of women who are overweight (body mass index [BMI] 25-30 kg/m2) or obese (BMI >30 kg/m2) when they become pregnant has substantially increased. Data suggests approximately 1 in 5 pregnancies fall into the obese category (Heslehurst et al., 2010), and it is projected that this will continue to increase due to a higher number of obese teenagers reaching child rearing age. Extensive research has documented that women with a high BMI during pregnancy are at greater risk of a series of physical and foetal health complications (Sebire et al., 2001). Evidence also demonstrates	Thank you for this comment. Weight management during pregnancy is outside the scope of this guideline and is covered by the NICE guideline on weight management before, during or after pregnancy. Nutrition during pregnancy is covered by the NICE guideline on maternal and child nutrition. Both guidelines are being updated currently. However, the committee recognises the importance of diet and nutrition during pregnancy and have included several references to nutrition, healthy eating and physical activity in the guideline. For

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				that women who are overweight and obese when they become pregnant are at a greater risk of antenatal and postpartum depression symptoms, compared to women with a normal weight (Molyneaux et al., 2014). Specifically within pregnancy, depression is known to be associated with higher maternal morbidity and mortality, and subsequent adverse implication on the cognitive, emotional and behavioural development of the child (Sattler et al., 2017) that can last until late adolescence (Stein et al., 2014). This has been further echoed in the Better Births Report with The Chief Medical Officer's 2015 annual report highlighting serious concerns about the effects of weight in women before, during and after pregnancy. Within the report, it again demonstrates that the increase in obesity rates among women of reproductive age not only influences their health, but also increases the risk of complications during pregnancy and is likely to compromise the health of their children. For example ,excessive gestational weight gain is also associated with obesity in the offspring (Oken et al., 2007) and it is also reported that the cost of obese pregnancy care is at least five times greater than that of normal weight mothers (Galtiere-Dereure et al, 2000). At the CECD, we are targeting diet and weight in pregnancy in a universal manner – we are embedding a psychological approach to diet and nutrition within our Baby Steps Antenatal class and are trialling a psychological health psychologist approach to specialised antenatal care in maternity services.	example, the committee agreed that early pregnancy information provided when the woman is first referred to antenatal care, should include information about healthy eating.

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				Following consultation with staff and the community, as well as drawing on evidence from the literature (some of which is listed above) it is anticipated that this will reduce the cycle of poor mental and physical health in pregnancy. Embedding clearer messages and support in services for reducing and controlling weight in the perinatal period is of paramount importance.	
NSPCC	Guideline	020 021	009-016 001-005	There needs to be an emphasis on participative, rather than didactic, learning methods that cover the following: • practical skills and knowledge for early childcare and parenting • the transition to parenthood, preparation for family life, co-parenting, changing roles and expectations • the emotional dimensions of parenthood, changing parent–parent (couple) relationships, mother–infant and father–infant relationships • parent bonding, care and nurture – understanding a baby's cues • encouraging social support	Thank you for this comment. Evidence on these types of elements of antenatal classes were not reviewed as such, however, some of these issues have been covered by the examples of topics to cover (not an exhaustive list) or elsewhere in the guideline. For example, the list of topics to cover include how to support each other throughout the pregnancy and after birth (latter was added after consultation), how to care for the baby, and how the parents can bond with their baby (with a link to the postnatal care guideline).
NSPCC	Guideline	020	015-016	We are concerned that there is not enough importance placed on conversations and education on how parents can support bonding with their baby (both unborn and newborn). In fact the point in this section does not	Thank you for this comment. Bonding and emotional attachment (both postnatally and antenatally) is covered by the postnatal care

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				even mention unborn baby only newborn we do not agree with the rationale outline by the NICE committee for this. It is not enough to focus on this postnatally. Please see further comments on this in example 1. – Example from Blackpool CECD on how this can be addressed in perinatal education: Baby Steps was developed by the NSPCC and the University of Warwick and is now the only antenatal education programme delivered in Blackpool. A combination of health visitors, midwives, community nursery nurses and NSPCC Family Engagement Workers engage mums and partners in this 9-week programme. It focuses on the transition to parenthood and the social and emotional impacts of this. In addition, it supports and encourages reflective function, which enables mums and dads to think what their baby may be like and promote early attachment. Through supporting parent infant relationships during pregnancy, this will support the later social and emotional development of children. The programme focuses on supporting parents to increase their reflective function and keep their baby in mind and also recognises the impact that having a baby can have on a couple's relationship. These themes were of huge importance before, but are even more important now during COVID-19.	guideline which we have referred to, they reviewed evidence on interventions starting in the antenatal period, not only postnatal period. We have also taken out the word 'newborn' from the recommendations in relation to bonding and emotional attachment as we agree that this could also relate to bonding and attachment with an unborn baby. Thank you for sharing information about the programme in Blackpool, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

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				The CECD Blackpool recognises the importance of supporting the parent infant relationship and that there is a need for services to support families in pregnancy and beyond where difficulties in the parent-infant relationship are suspected and/or identified. A specialised Parent-Infant Mental Health Service is being developed in Blackpool. This is a "specialised multi-disciplinary team with expertise in supporting and strengthening the important relationships between babies and their parents/carers" (Parent Infant Foundation, 2019). The service is early intervention service that will focuses on promotion, prevention, the development of the local workforce and treatment. The service will be the only service to work with carers and infants across the spectrum of mental health conditions. Pregnancy and the first year of life are a critical stage in a child's development and an important time for parents when they might be more likely to seek help and engage with support. Extensive evidence now demonstrates that experiences during pregnancy can have a significant impact on children's developmental outcomes. Despite this, antenatal education is often highly variable and can fail to reach those who would most benefit from it. Antenatal education also typically fails to engage and support fathers, despite the critically important role that they have during this life stage. Baby Steps directly addresses these issues; making a difference to children's lives by engaging both fathers and mothers effectively during pregnancy and around the birth of their child, and covering a range of issues that include the social and emotional aspects of becoming a parent.	

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				Baby Steps has been Blackpool's universal antenatal education programme since April 2017. All Health Visitors are now trained to deliver the programme, alongside nine Family Engagement workers. The outcomes of Baby Steps in Blackpool, on a universal scale, are similar to the positive national outcomes delivered to 'targeted families'. Parents are very enthusiastic about the programme, and report that it gives them new knowledge that prepares them for parenthood and helps them to feel more confident as parents. Quantitative evaluation shows that parents who attended Baby Steps: • Showed an improvement in the quality of their relationship with their babies • Had increased satisfaction in their relationships with their partners • Showed a decrease in anxiety and depression • Had increased levels of self esteem • Had lower rates of caesareans, low birth weight and premature babies compared to the general population • Were 20% more likely to be breastfeeding at 6-8 weeks	

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NSPCC	Guideline	035	008-025	Of those becoming pregnant, at least four out of five will likely have experienced one potentially traumatic event in their lives; and although most women with a history of childhood sexual abuse or trauma have normal, uncomplicated pregnancies and births some experience a range of difficult emotional and physical responses as well as obstetric complications and subsequent new or re-emerging mental health issues. Importantly, the guidance does not reflect that it is those expectant mothers who are much more likely to present late to services. Without this understanding, it can mean that the needs of these individuals are not met, and their experiences not taken into consideration. This leads to a higher number of women experiencing postnatal depression, anxiety, OCD and other mental health difficulties. Understanding why an individual has presented late to services is essential to ensure care can meet the needs. In addition, most fathers, male or same-sex partners, with similar experiences of adversity or trauma, do not find the transition to parenthood any more challenging than those who have not had such experiences. Others may experience a range of difficult emotional and physical responses as well as subsequent new or re-emerging mental health problems. The guidance is extremely practice based and includes key theory and concepts but also how to apply these in practice. Staff understanding and recognition of this is essential.	Thank you for this comment. Based on your and other stakeholders' comments, the committee added a recommendation about trying to understand the reasons for late booking in case they reveal any social, psychological or medical issues that may need addressing. Some other revisions have also been made to explicitly refer to previous emotional trauma. We hope that these revisions have improved the guideline.

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NSPCC	Guideline	037	001-025	It is important that the guideline recognises that expectant and new mothers are affected by the attitudes and behaviour of their baby's father. His support is important for the mental health and wellbeing of the mother, the baby's health and development and the couple relationship. In becoming a parent, a father also goes through an important life change that is separate from the mother's experience. He needs information and support that specifically address his needs and that help him to adjust to his new role. Many fathers feel that antenatal education does not help them to adjust, and they are sometimes made to feel excluded. This has been clear through our research and in the literature – we have tried to emphasises this in the NHS E/I guidelines listed above.	Thank you for this comment. The committee agrees with the point about the influence that a partner can have on the pregnant woman. We have revised the text to include this point. The committee also recognises that the woman's partner is often an expectant parent themselves and being involved in antenatal care, if the woman wishes, can provide them with information and support. The guideline recommends that partners are provided with information alongside the woman. The guideline also recommends that throughout pregnancy discussions should be held around relationship changes and how the woman and her partner can support each other. The recommendation on what topics to cover in antenatal classes also include how couples can support each other during and after pregnancy. The section on 'Involving partners' includes recommendations around how antenatal care could be made more welcoming to partners. We hope that these various sections in the guideline cover many of the issues raised in your comment.
NSPCC	Guideline	048	007-020	Antenatal preparation courses can lead mothers and fathers to adopt a range of healthy behaviours that affect pregnancy, birth and early parenthood (as	Thank you for this comment which the committee discussed. The topics listed are examples and it is not an exhaustive list. The

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				well as their own health), such as eating more healthily, cutting down or stopping smoking and taking more exercise. Group-based antenatal programmes that include topics on couple relationships, co-parenting, gender issues and father involvement, parenting skills, bonding and attachment, and problem-solving skills are associated with improved maternal well-being and with an increase in the confidence and satisfaction of both parents with the couple and the mother–infant/ father–infant relationships (Schrader McMillan A, J Barlow and M Redshaw (2009) Birth and Beyond: A review of the evidence about antenatal education, University of Warwick/University of Oxford, available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/ digitalasset/dh_110371.pdf	committee wanted to avoid being to prescriptive. However, some revisions have been made in the list, for example about how partners/parents can support each other also after birth (not just during pregnancy).
Obesity Group of the British Dietetic Association	Guideline	General	General	We would like a recommendation made about the need to provide and fund training on raising the issue of weight & weight management with pregnant women and their partners; lack of confidence or fear of damaging the therapeutic relationship may result in practitioner reluctance to do so. This is an unequalled opportunity to frame healthy weight to women and their partners at a time when they may be more receptive to the messages, with potential benefits to both them and their babies.	Thank you for this comment. Weight management during pregnancy is outside the scope of this guideline. This would rather fall in the remit of the NICE guideline on weight management before, during or after pregnancy which is currently being updated.

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Obesity Group of the British Dietetic Association	Guideline	012-013	001-007 014-018 013-015	There is a focus on BMI at or above 30kg/m^2 triggering concerns (e.g. hypertension, venous thromboembolism, gestational diabetes). While this is appropriate for Caucasian women, there may be lower BMI cut-off points at which increased risk is present for women from some BAME groups. It is recognised that those from BAME communities have increased risk of diabetes and other health conditions at lower BMI cut-off points than Caucasian groups although specific cut-off points have not been agreed within the UK (PH46 BMI: Preventing ill health and premature death in Black, Asian and other minority ethnic groups). Nonetheless, the same guidance suggests lower public health trigger points are used (BMI of 23kg/m^2 for increased risk and BMI of 27.5kg/m^2 for high risk), although this guidance excludes women who are pregnant. Nonetheless, there is no recognition in this guidance of potential increased risk for BAME women at lower BMI, despite the increased risk to BAME pregnant women during Covid-19.	Thank you for this comment which the committee discussed. However, because this issue is not in the remit of this guideline the committee agreed not to change anything in the recommendations. As you say, the NICE guideline PH46 excludes pregnant women. However, because this is a potentially important issue we have noted this in the committee's discussion section in the evidence reports G and N.
Obesity Group of the British Dietetic Association	Guideline	006	002-004	We would like 'raised BMI and/or excess weight gain' specified as risk factors in the referral form	Thank you for this comment. The committee agreed not to be too prescriptive in the recommendation, however, wanted to emphasise factors that could be addressed before booking appointment, perhaps most importantly smoking. Furthermore, the committee agreed to add that the early pregnancy information provided at the time of referral to antenatal care should include information on for example healthy eating.

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Obesity Group of the British Dietetic Association	Guideline	010	008-015	We are disappointed that there is no recommendation for weight measurement at each antenatal appointment, which means that gestational weight gain (GWG) cannot be monitored. There is a link in the recommendations to current guidance PH27 [Weight management before, during and after pregnancy] in which it states 'Do not weigh women during pregnancy as a matter of routine'. Within the US, recommendations for GWG according to pre-pregnancy BMI have been made (IOM, 2009), but this is not currently the case within the UK. A systematic review in 2017 (Goldstein et al JAMA 317(21): 2207-2225) demonstrated that GWG lower or higher than the IOM recommendations was significantly associated with adverse outcomes for both mothers and babies. This large systematic review did not include UK data but did include 8 studies from Asian, 5 from Europe and 10 from the USA. It is our view that women should be weighed at each antenatal visit in order to gain a longitudinal assessment of the amount and rate of weight gain, both of which are important for health and wellbeing of the mother and child. It is unclear how the risks associated with low or high GWG may be mitigated without measurements allowing GWG to be recorded throughout pregnancy. This is not a high resource intervention since no additional visits are required and weighing scales are standard equipment; height will already be recorded as recommended in the first antenatal appointment.	Thank you for this comment. Weight monitoring and management is not in the scope of this guideline and therefore evidence on it has not been reviewed and further recommendations have not been made. The referenced study may be more relevant to the remit of the NICE guideline PH27 on weight management before, during and after pregnancy which is currently being updated.

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Obesity Group of the British Dietetic Association	Guideline	010	002-004	At the first antenatal appointment, we would like 'discuss excess weight gain and risks' with pregnant women and partner added.	Thank you for this comment. Weight monitoring and management is not in the scope of this guideline and therefore evidence on it has not been reviewed and further recommendations have not been made.
Obesity Group of the British Dietetic Association	Guideline	010	002-004	At the first antenatal appointment, weight and height should be measured. If BMI is raised, what then? The actions a rising from BMI which is not ideal needs clarification for practitioners.	Thank you for this comment. This issue is not covered by the scope of this guideline and therefore evidence on it has not been reviewed and further recommendations have not been made. This seems more relevant for the NICE guideline on weight management before, during and after pregnancy which is currently being updated.
Obesity Group of the British Dietetic Association	Guideline	019	004	We would like discussion of nutrition and physical activity to be specifically included throughout the pregnancy; the booking appointment has a lot of information, and revisiting these two essential topics at subsequent antenatal appointments would highlight their importance.	Thank you for this comment. The committee has added to the previous recommendation on discussion on nutrition, physical activity and so on that this should be discussed at booking appointment and later, if appropriate.
Parent Infant Foundation	Evidence review A	018	019-021	The document states that "that having no emotional attachment with the baby in the 19 antenatal period did not necessarily mean the woman would not bond with the baby after birth. The committee agreed that it was not	Thank you for this comment. The committee discussed the importance of bonding and attachment with the baby during the antenatal period. The guideline recommends discussing the

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				appropriate to dwell on this as it may cause the woman anxiety." However, there is evidence that a lack of maternal bonding to the foetus is associated with an increased risk of parent-infant difficulties postnatally. Therefore it is important to identify this issue so that it can be acted upon.	issues of bonding and emotional attachment with expectant parents during pregnancy during appointments and classes. The NICE guideline on postnatal care covers issues related to emotional attachment and bonding, including how some parents may need additional support in bonding with their babies, and we have referred to that section in the postnatal care guideline in the antenatal care guideline.
Parent Infant Foundation	Guideline	General	General	There is a fundamental question that underpins this guidance, which is "who is antenatal care for?" The current guidance is written as if there is only one patient – the woman. In fact, the midwife is caring for a mother and her unborn baby. If the guidelines were to acknowledge that there are two patients, then document would be very different. It would recognise the child's needs and rights, and the fact that a child (usually) has more than one parent and benefits from both parents being involved in their care, from conception.	Thank you for this comment which the committee discussed. The committee considered this issue very carefully throughout the development of the guideline. This guideline addressed care for both the pregnant woman and the baby and in all the evidence reviews, health outcomes for the baby as well as for the woman have been looked at. However, care for the unborn baby is never independent of the woman, so the care for the baby always goes via the woman and the guideline needs to address the woman as she is the "patient" receiving the care. Throughout, the committee has also carefully considered partner's involvement (usually the baby's parent), parental relationships and the impact and role that the other parent has in antenatal care and this has been reflected

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					in the recommendations, including the section on "Involving partners".
Parent Infant Foundation	Guideline	007	004-021	The document talks of partners only as people who might support a mother through her pregnancy. It is important that midwives engage fathers or partners as parents who might have their own needs and challenges in this period. As parents of the baby, fathers and partners need information and guidance on their parenting role and also signposting/referral to support to address any challenges they may face. In some cases, fathers or partners may experience issues that make them a risk to the mother or baby's wellbeing, and it is important that this risk is understood, assessed, recorded and acted upon. Given the compelling evidence on the value of partners to the health and wellbeing of the baby, the pregnant woman and the partner, the language of this draft guidance is insufficiently direct about the imperative to engage the partners of pregnant women. The language of a woman "can" be supported by a partner should be changed to "encouraged to". The guidance should also highlight ensure that a woman and her partner are told that fathers/partners are entitled by law to paid time off to attend two antenatal appointments	Thank you for this comment. The recommendations on information and support for pregnant women and their partners cover how fathers and partners can get information and guidance on their parenting role and how midwives can support this, if it is in line with the woman's wishes. The guideline aims to address this, however, the committee recognised that women's home and family circumstances vary, and it is up to the woman to decide who she may want to involve in her antenatal care. The committee discussed that many women may be in coercive relationships and experience domestic abuse the guideline need to consider that the woman's autonomy and safety are paramount as this guideline is first and foremost for the woman. Given the baseline that the involvement of her chosen partner is based on her wishes, the guideline then goes on to recommend that discussion are held and information is provided to both the woman and her partner.
Parent Infant	Guideline	008	004-020	It is important that a woman is asked about any previous children, if she has required support in her role as a mother before and/or if there have been any previous safeguarding concerns or involvement with children's	Thank you for this comment. The committee agreed that it is important to know about her 'previous' children as well as her family and

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Foundation				social care. This is a significant omission as it means that opportunities to provide support and assess risk during pregnancy may be lost. During the antenatal period a midwife should talk to the woman about past or present involvement with early help or social care services and find out other information about previous children that could help build a picture of her support needs and any risks to the baby that should be managed. This would also alert a midwife of the need to connect with other services.	home situation in general and the support she has. The committee therefore revised the recommendation wording about asking about her family and home situation, the support she has and any issues related to her family members that might have an impact.
Parent Infant Foundation	Guideline	010	08-017	During antenatal contacts, professionals should explore a woman's feelings about her unborn baby and her bonding with the child. A lack of maternal bonding to the foetus is associated with increased risk of parent-infant relationship difficulties postnatally. Failure to notice antenatal bonding difficulties may miss the opportunity to intervene early to prevent more substantial attachment difficulties postnatally. This topic needs further consideration in these guidelines.	Thank you for this comment. We think that this is covered in the guideline although the committee did not want to be prescriptive in terms of exactly how and when this issue should be discussed. There is a recommendation in the guideline that says that throughout pregnancy bonding and emotional attachment should be discussed and given information on, and a reference to the section on postnatal care guideline which covers bonding and emotional attachment (also covering the antenatal period). We have revised the recommendation to refer to 'baby' and not 'newborn baby' because the committee agrees this also includes the unborn baby. Furthermore, the guideline recommends

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					that antenatal classes should also cover issues around bonding and emotional attachment.
Parent Infant Foundation	Guideline	020	015-016	We welcome the recommendation to give all parents to be information about bonding and emotional attachment as part of antenatal education.	Thank you.
Pelvic Partnership	Guideline	029	007-011	Response to Recommendation 1.4.12 Thank you for inviting us to comment on this guideline. We completely disagree with recommendation 1.4.12 which takes management of PGP back to the 1990s by disregarding the safe and effective treatment of PGP with hands-on manual therapy. This would be a retrograde step to women's healthcare services which now offer individualised care including manual therapy, and which support women to make a good recovery during pregnancy and postnatally. Early intervention, i.e. early assessment and treatment of PGP, also reduces the cost of early induction, maternal request caesarean birth, postnatal pain relief and antidepressant medication, and treatment for the physical and psychological consequences of pain, immobility and not being understood which follow the very outdated treatment regime of belts and crutches (as outlined in the Irish CPG for management of pelvic girdle pain).	Thank you for this comment, and for the suggested wording for the recommendation relating to pelvic girdle pain management. The committee used available evidence to make the recommendations and revisited this evidence after your comment but there was no sufficient evidence to support manual therapy for pelvic girdle pain and the committee agreed to not change the recommendation. The remit of the evidence review was the clinical management of pelvic girdle pain and elements of care beyond that such as psychological support and birth plan discussions were outside the focus of this review and thus not commented on. Thank you for sharing various references, we have cross-checked them against the criteria set in the review protocol. The guidance you refer to: Royal College of Obstetricians & Gynaecologists

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				Furthermore, a service which implemented individual assessment and treatment with manual therapy for joint and muscle imbalance in Norwich showed a 2/3 reduction in the need to provide crutches, reduction in antenatal bed-rest for immobility due to PGP, reduction in induction and caesarean birth, and very few women needing postnatal treatment beyond 3 months postnatally. This produced an overall cost saving to the service. The proposed recommendations will perpetuate the outdated treatment, based on the outdated assumption that PGP is a hormonal condition rather than a biomechanical joint dysfunction, and result in significant physical and psychological consequences for women. They also contradict the RCOG guidance, the POGP guidance for healthcare professionals (Pelvic, Obstetric and Gynaecological Physiotherapy special interest group) and the NHS Long Term plan which is focussing on pelvic health including the pelvic floor and PGP. We would suggest that the recommendation should read: 1.4.12 For women with pregnancy-related pelvic girdle pain, consider referral to physiotherapy services for individualised assessment and treatment including manual therapy, exercises and advice. If the pain continues, consider providing aids including crutches and referral to an occupational therapist.	information on pelvic girdle pain in pregnancy; Pelvic Obstetric & Gynaecological Physiotherapy guidance on pelvic girdle pain for women; Pelvic Obstetric & Gynaecological Physiotherapy guidance on pelvic girdle pain for healthcare professionals; Clinical Practice Guideline: Management of pelvic girdle pain in pregnancy and post-partum (Ireland); cannot be included in the evidence review as they do not meet our study design criteria as set out in the protocol. Albert 2001 and Malmqvist 2015, are not randomised controlled trials and therefore cannot be included in the evidence review as per criteria set out in the protocol.

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				Consider psychological support for women with significant pain and immobility due to PGP. Offer discussion about birth planning to take into account the woman's immobility. Women with mild to moderate PGP We are very concerned that the review focused on women experiencing mild to moderate PGP only, therefore disregarding those women most impacted by this severe and painful condition. As per our attachment, testimonies from women with PGP underline the importance of ensuring the guidance reflects best practice in the treatment of PGP, i.e. a multidisciplinary and individualised treatment plan including manual therapy to treat the cause of the pain and psychological supports, rather than a "band aid approach", as one healthcare professional referred to it when we consulted about the draft guidance (see statements below). Critical and important outcomes The outcomes selected only included symptoms during pregnancy, and did not take account of the fact that the majority of women do not recover postnatally, and 8.5% continue with significant symptoms 2 years postnatally (Albert et al, 2001).The evidence review lists pain intensity, pelvic disability/functionality and women's experience and satisfaction as	

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				critical outcomes. The significant response to our social media posts on this draft guideline (reaching 3500 women in 5 days, with over 35 comments and emails) and the powerful testimonies listed below show that clear action needs to be taken to improve women's experience and satisfaction. Lost work days due to PGP was also listed as an important outcome: "women with a high degree of self-reported PGP have longer sick-leave duration than others, and these pain symptoms were in one study reported to bring about 80% of sick leaves during pregnancy. The authors argued that this makes PGP during pregnancy a major public health issue" in Malmqvist et al (2015). These factors point to the need to consider the significant mental health impact of PGP. Our own survey of 367 women in June 2018 found two thirds of respondents with PGP also experienced a mental health issue. Comments from healthcare practitioners (see attachment) supports this as the manual therapy is part of their multidisciplinary and individualised approach, supported by an understanding of the wider impact on a woman's life of PGP. This is why we are calling for psychological support to be considered in the recommendation for women with PGP. Evidence for the benefits of manual therapy	

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				We are also disappointed that manual therapy was not included in the economic analysis, despite being listed as an intervention in the PICO. There was some comparison made about manual therapy in the context of chiropractic treatment, craniosacral therapy and foot manipulation, none of which are normally available on the NHS. We consider this a missed opportunity to assess the real benefit of mobilisation and manipulation of the joints using physiotherapy manual treatments along with muscle release techniques including trigger point and dry-needling treatments. The latter is the commonly accepted definition of manual therapy among healthcare professionals in the UK (as outlined in the various UK and Irish guidance listed below). Indeed, we are unaware of foot manipulation and craniosacral treatment being successfully used in the treatment of PGP in the UK even outside the NHS. The evidence review cited limited evidence as a barrier to include manual therapy in the recommendation. Please see list of guidance recommending manual therapy to treat PGP below: • Royal College of Obstetricians & Gynaecologists information on pelvic girdle pain in pregnancy advice includes "manual therapy to the muscles and joints by a physiotherapist, osteopath or chiropractor who specialises in PGP in pregnancy. They will give you hands-on treatment to gently mobilise or move the joints to get them back into position, and help them move normally again. This should be painful."	

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				• Pelvic Obstetric & Gynaecological Physiotherapy guidance on pelvic girdle pain for women includes assessment and treatment from a physiotherapist, e.g. exercises, advice and "manual therapy to make sure your spinal, pelvic and hip joints are moving normally or to correct their movement", adding that PGP can be treated effectively in one or two sessions with a physiotherapist. • Pelvic Obstetric & Gynaecological Physiotherapy guidance on pelvic girdle pain for healthcare professionals includes assessment and treatment from "a physiotherapist who has appropriate training and expertise in PGP management and treatment" offering exercise, advice and "appropriate manual therapy as required, e.g. mobilisations, manipulation, muscle energy techniques, stretches. Manual therapy should be aimed at correcting any spinal pelvic and hip joint dysfunction including increasing hip join mobility". • Clinical Practice Guideline: Management of pelvic girdle pain in pregnancy and post-partum (Ireland): includes "Physiotherapists trained in the assessment and treatment of PGP may use any or all of the following in the management of patients with PGP; advice and education, joint mobilisations, myofascial and trigger point techniques, muscle energy techniques, acupuncture, TENS, massage, specific individualised exercise programmes and pelvic belts"	

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				Multidisciplinary approach We promote manual therapy as part of a multidisciplinary and individualised approach to treating PGP, recognising that women experience PGP differently. Exercise and support belts when used in conjunction with manual therapy can help maintain the correct alignment of the pelvis, after assessment and treatment by a manual therapist. However, these approaches do not work in isolation, especially for moderate to severe cases of PGP. We are concerned that by offering exercise advice or belts without a thorough assessment of the woman by a manual therapist, these approaches will do little to resolve the PGP and will lead to further issues later in pregnancy, during the birth and postnatally. This is supported by the findings of our June 2018 survey and feedback from our service users and healthcare practitioners, included below. We call on the committee to review recommendation 1.4.12 and ensure the guidance reflects best practice, i.e. referral to physiotherapy services for individualised assessment and treatment of pelvic girdle pain, using manual therapy, exercises and advice, with additional referrals to psychological support and/or occupational therapy as needed.	

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				Representatives from the Pelvic Partnership would also be happy to be co-opted onto this committee to assist with the review of the recommendation. Supporting statements from service users and healthcare professionals To support this submission we asked our online community of service users and healthcare professionals to respond to the NICE draft recommendations. We received 35 comments and 8 emails in four days. None agreed with the NICE draft guidance. All wrote supporting our position to change the recommendation, 14 of which we have shared below: 1. Woman with PGP: It did zero for me. I had a support belt, tubi grup covering my torso and crutches with my first. It just got progressively worse until I needed to sit in a wheelchair - which I struggled to sit in anyway. By the magic of manual therapy I needed nothing else in my other pregnancies! 2. Woman with PGP: Manual therapy (and mental health support) for all women needs to come as standard with a pelvic girdle pain (PGP) diagnosis. Exercises and support belts do not treat the	

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				underlying problem and in some cases, like mine, can significantly worsen the condition. For me, this resulted in an inability to function on a day to day basis (washing, dressing, feeding myself, walking etc) and an intolerable level of pain resulting in significant knock on effects for me physically, mentally and emotionally, to my family who had to watch me suffer, as well as the NHS in terms of subsequent costs. When I eventually got seen by an NHS physio, I was fobbed off and told I was "too severe" to treat which was rubbish because at the time I could actually walk (I later ended up in a wheelchair). I was told to exercise, use a support belt and crutches which did nothing but make everything worse (because I was pushing myself too hard and not listening to my pain as I later found out I should have been – a one size fits all set of guidelines is so dangerous and unhelpful with something as complex as PGP) and make me seriously depressed because I was doing everything I "could" and had been told to and the pain was increasing exponentially! Little did I know I had a problem which just needed to be treated with manual therapy. Luckily, I found a private practitioner via the Pelvic Partnership who saved me because at 30 weeks I was suicidal and done with pregnancy. My PGP traumatised me and I needed so much help both mentally and physically because I hadn't had the right treatment soon enough and my issues dragged on for many months after (not helped by lockdown where, for some reason now, NHS physios are rarely	

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				treating patients face to face where private physios like mine are). Not to mention the fact that I had to have a c section as a result of my severe PGP. I appreciate physios are an expensive and high demand resource but the knock on effects and cost to the NHS of all my subsequent issues were FAR greater than the cost of a physio would have been. Your report completely underplays how debilitating PGP is or how severe it can become and how much it affects women mentally too. I had two years of hell and if I'd have just had the right treatment when I went to the NHS in the first place, it wouldn't have been half as bad! It literally ruined my pregnancy and ruined my first 6+ months of life with my son, and I can never get that back! I very much hope you will reconsider. I wouldn't wish my pain and suffering on my worst enemy but reading this just makes me wish that someone in your organisation knew what it was really like even if just for a few seconds so you would take it A LOT more seriously. Finally, for me, the scariest thing is that by making it sound like manual therapy doesn't work, people wouldn't know about it or bother to pursue it privately (if they can afford to (sadly many cannot) or get charity funding). I implore you, at the very least, to acknowledge that it can be highly effective and even if the cost cannot be justified as part of your guidelines, women will know that there is something that can be done to help them and that they're not destined to never be able to walk or function again without pain. Of course I wish that	

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				everyone who needs it could get specialist physio for free on the NHS but if they cannot (because in my opinion the wider implications and costs have not been fully considered), at least acknowledge the effectiveness of manual therapy and help to educate and inform them because that is free! PS I'm sure you're well aware of information like this demonstrating how much sick leave is caused by PGP: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0667-0 3. Chiropractor: This is such upsetting advice, and such a band aid approach root cause is being missed! Yes, exercise is helpful, as is some belt support, but misses the point! Mention in your reply that Research shows 72% of missed work days in pregnant women are due to PGP! 4. Osteopath: Absolutely, root cause individualised approach is key. Understanding each individual and their individual reasons for getting PGP. Please ensure that you advocate not just for physio, but for Osteopathy too. We know it works. This should be on the recommendations. Plus the importance of a multifaceted approach. Including stress management, and addressing fear and anxiety... previous birth trauma. The recommendation for improving access to Osteopathy for PGP means we can spend time signposting	

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				other services like these to help improve PGP and birth outcomes too if and when needed and necessary. 5. Physiotherapist: Manual therapy all the way 6. Physiotherapist: Manual therapy is so essential for the management of PGP 7. Exercise trainer: I shall be filling this out and sending in and also put this out to clients from XXXX. This lack of service and help needs to change. It's gone on long enough! 8. Woman with PGP: Hi there, I suffered from PGP in my first pregnancy from 16 weeks. No midwife would refer me for physio (because I could never get in touch with a midwife) and I had to go through my GP. It was so bad that I was offered a 4 week sick note to help me get some rest. I heard nothing back from the NHS, so assembled a team of a brilliant physio and a chiropractor. Women's ante-natal care is a disgrace. If you're low risk, it's honestly like nobody really cares. The following pretty much sums up my journey of ante-natal care: No named midwife/contact A different midwife at every single appointment. On reflection, I was really anxious in my first pregnancy, but couldn't share this with anyone as I never had the opportunity to build a relationship with	

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				someone who was a constant in my care. No physio provided through the NHS for PGP. I struggled with insomnia from 8-32 weeks and no support was provided apart from the suggestion that I should try to relax/use lavender. Refusal from GPs or anyone to prescribe anything to help with heartburn. My child was breech, but this wasn't detected until 36 weeks because I felt the pattern of movements was off/he hadn't dropped/family history of breech presentation. I had to really fight for a scan to check position. Being told by sonographers at the 36 week scan that even if he was the right way, he was an estimated weight of 9lb and that I wouldn't have been able to give birth to him anyway. Medical staff need to make women aware that the margin of error on an ultrasound scans can be up to 750g either way. That's a pound and a half. Scare mongering over size (unless there are genuine concerns/baby has fallen off the centile chart/identified problems with core blood flow and placenta) should not happen. Nutrition and management of women who are awaiting induction or Caesarian section. On the day of my section I was admitted at 7:30am and was not allowed to eat or drink until I had been out of theatre an hour. That was 6:30pm before I was allowed to drink anything. Then it was clear liquids for an hour before I was finally allowed to eat at 7:30pm. I had been nil by mouth with solids since 8pm the night before and wasn't allowed any liquids past 6am on the morning of surgery. How can you be expected to recover from	

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				9. Woman with PGP: Gosh they're not making it easy with this documentation are they?! I will definitely complete and send on though. The current 'support' from the NHS is truly awful and things must change. 10. Chiropractor: Thanks for flagging upcoming changes in NICE guideline re PGP. Worrying. I recently listened to the back pain podcast episodes with Physio Sarah Fellows. Really good and worth a listen. So much of what we do as manual therapist foes beyong the hands on mechanical effect on joints, it is about listening, reassuring, calming the system which can be done with the laying on of hands. Good care is about providing an appropriate mutlifaceted approach to care... not just dishing out belts! Also about providing good quality physical examination and assessment to determine if indeed the diagnosis is PGP. 11. Woman with PGP: Whom it may concern,I have recently seen an advert with the pelvic partnership charity about getting manual therapy recognised by NICE. I just wanted to share with you my story. At 26 weeks pregnant I started with the worst pelvic pain, I was referred to NHS physio and advised to loose weight (I have a high BMI) and wear a support band on my bump. I ended up finishing work at 32 weeks pregnant as I couldn't work with the	

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				pain. After giving birth the pain was still there. After 4 months I rung the DR's I was prescribed Naproxen, referred to physio and told to exercise. Three months later I was seen by physio who had no experience or knowledge on PGP and gave me an exercise program. However, after a few weeks of following the exercises, I found my pain had become unbearable and was now requiring amitriptyline at night time. Again Dr's and physio where telling me to continue exercising and loosing weight. I discovered to pelvic partnership charity and wrote to them with my symptoms and they recommended seeing an osteopath. My first meeting with the osteopath he told me the advice from the Dr's and physio to exercise is what had made my PGP worse; My pelvis coupsnt withstand the numerous squats and lunges. After 2 months of seeing an osteopath weekly, and following some appropriate light stretches daily, I can now sit on the floor and play with my child. I can walk upstairs without crying. I can work without having to sign of sick for days following a shift. I can enjoy family walks. My daughter is 14 months old, I suffered miserably for 17 months with PGP being wrongly advised by professionals. I urge you to make the change and recommend manual therapy to ladies pre and postpartum that suffer with PGP. It IS treatable. Unfortunately like me, who is a nurse and works of evidence based practise I was very against paying for something that wasn't recommended, and	

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				I'm certain there will be ladies out there suffering because they had the same mind set as me. 12. Woman with PGP: Hi, I am very concerned about the guidance for pelvic girdle pain. I have had PGP since 14 weeks pregnant and was referred to an NHS physio. Only offered exercise advice and support belts which has not helped and was told to limit my movement if exercises made the pain worse. I've been unable to walk or get any exercise throughout my entire pregnancy. My pain and mobility has steadily increased and from 35 weeks pregnant I couldn't move without crutches - couldn't sleep as the hip pain was so bad. Evidence shows that manual therapy should be standard practice. This needs to be offered to all women. The impact on my physical health and mental health has been awful. Pelvic girdle pain For women with pregnancy-related pelvic girdle pain, consider referral to physiotherapy services for: • exercise advice and/or • a non-rigid lumbopelvic belt. 13. Woman with PGP: Hello I would just like to add my comments to your comments that will be submitted to NICE. I have had problems with my hips since the start of pregnancy my GP and Midwife put it down to just being pregnant. At 33 weeks pregnant I was then unable to walk, I could just about get around my house. A referral was sent for physiotherapy but manual therapy was not	

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				offered, the exercises seemed to be impossible to do in my immobile condition. I had to seek out private manual therapy from a PGP therapist, after one session of manual therapy she told me my right hip was two inches higher then my left, putting considerable pressure everywhere and making me immobile. Two days later I am able to walk pain free. I am a fit, healthy NHS specialist nurse, I find the fact that a physiotherapist does not have to physically assess you quite shocking. In my profession I would not be able to assess a patient without seeing them. I also worry that many women are being left untreated, I am lucky I had the knowledge and money to seek private help, however I do believe that it should be mandatory for manual therapy to be gold standard in regard to this condition. Without the manual therapy I would have slipped into a very depressive state. 14. Woman with PGP: Last year I had my baby in April, so mostly pregnant pre Covid, during my pregnancy I suffered with severe PGP that resulted in me being bed bound at 30 weeks. I was referred to the physio in my area by my consultant. It was a group therapy session with absolutely no physical or personal assessment done. I was then advised to do pelvic floor exercises religiously, as it happens I have been doing these for 20 years and have since been told by my private womens health physio that my pelvic floor is 5/5 and one of the strongest she has ever examined. My point is	

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				that clearly the pelvic floor was not the issue and the NHS physio was hugely lacking in knowledge on PGP. After the group session I took the physio aside to ask where we went from here, she said she would strongly recommend crutches and she would happily teach me how to use them. She still hadn't done any assessment of my personal symptoms. I asked about manual therapy and was told that that was not something she would do, that that wasn't suitable. I went home and cried for 2 days, the pain was horrific and I couldn't even move around my house without help, and now I had no hope. Next I started googling and found a pregnancy chiropractor 60miles away who I rang and spoke at length to. She said absolutely she could help me. And she did. With manual therapy. The relief was instant, I still walked like an old lady but the pain was greatly reduced. Due to not receiving treatment sooner I had to have twice weekly sessions until lockdown put a stop to that and I was once again bed bound for the last 5 weeks of my pregnancy. After the birth I was relatively pain free until 8 weeks postpartum when I had a relapse, luckily chiropractors were open again and I got help. To date, since the birth, I've had over 20 appointments with my chiropractor and 4 with a womens health physio and I'm having a much better quality of life although I still have to get adjusted every 3 weeks. PGP needs to be understood by the people whose job it is to care for pregnant women, the mental health element of being unable to take even 2 steps	

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				without agonising pain is unacceptable when treatment is available and so very simple. Thank you for listening.	
Pelvic, Obstetric & Gynaecological Physiotherapy (POGP)	Evidence review 1.4.12	006	General	Management of pelvic girdle pain in pregnancy – acupuncture, we wish to say that although the evidence may be poor, clinically some people find acupuncture very beneficial	Thank you for this comment. NICE recommendations are based on the best available evidence which the committee carefully reviewed alongside considering the potential for a resource impact. Based on the evidence, the effectiveness of acupuncture for pelvic girdle pain was not considered to be sufficient to justify a recommendation which could have significant resource implications. The full discussion of the committee's reasons for recommendations based on available evidence can be found in the 'Committee discussion of the evidence' section of evidence review U.
Pelvic, Obstetric & Gynaecological Physiotherapy (POGP)	Guideline	020	012	For classes could it be more specific that pelvic floor muscle training should be part of this. It is mentioned in the evidence review but given the RCM/CSP joint statement & the 10 year plan push it should be more specific	Thank you for this comment which the committee discussed. The topics listed are examples and it is not an exhaustive list. The committee wanted to avoid being to prescriptive. Pelvic floor exercises have been added to the recommendation about what information should be provided and discussed at appointments after 28 weeks.

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Pelvic, Obstetric & Gynaecological Physiotherapy (POGP)	guideline	029	011	The information to support the use of the non-rigid lumbopelvic belt is based on the findings of 1 RCT with 3 comparison groups of only n30 in each group. As a result of this outcome the committee has done extensive economic modelling on the cost versus benefit of lumbopelvic belts. We can only assume that this is because it is a passive and relatively cost-effective option (if effective) compared to 1:1 intervention. It is important to note that the RCT all women received general information and that the participants were 'chosen' for the study. Having been 'chosen' they were randomly allocated to the groups but the delivery of the a) information b) exercise c) belt application was not. There was no detail on who or how or what information or type of delivery of the interventions. Based on this we think that a recommendation of the use of lumbopelvic support belt is misleading. Whilst they may be of benefit there is insufficient data, like all other treatments, and as such we cannot see that they should be 'recommended'. Also, we feel that we will be back to the old situation of people just being sent for a belt and not for holistic treatment. For lots of women practically a belt is not indicated, or tolerated	Thank you for this comment. The evidence on lumbopelvic belts, both clinical and cost effective evidence was carefully considered by the committee including formal sensitivity analyses around assumptions and parameters in the economic model. The committee believed there was sufficient effectiveness and cost effectiveness evidence to recommend lumbopelvic belts, however given a number of weaknesses with the study, including those highlighted by yourselves, a less strong 'consider' recommendation was made. Assessment and discussion of the evidence is documented both in the clinical and economic sections of the relevant evidence report and the 'Rationale and impact section' of the guideline.

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				We commend the inclusion of referral to physiotherapy services	
Pregnancy Sickness Support	Guideline	050	020-021	Non-pharmacological treatments are widely known and tried by pregnant women and women whose symptoms are mild enough to be helped by non-pharmacological treatment do not generally seek help from a healthcare professional. Women whose symptoms warrant seeking help should be reassured that pharmacological options exist and that being pregnant doesn't exclude the use of pharmacology.	Thank you for this comment. The guideline committee discussed this and revised the recommendations accordingly, including adding a recommendation about recognising that by the time women seek help to nausea and vomiting in pregnancy many have already tried various self-help methods, and that different pharmacological options are discussed with women seeking pharmacological interventions for their nausea and vomiting.
Pregnancy Sickness Support	Guideline	050	019	It is important to note that mild pregnancy sickness is an expected part of pregnancy which women anticipate and often embrace as part of the pregnancy experience, most women tolerate quite severe symptoms and attempt various self help techniques before seeking medical help. Therefore when women feel symptoms are severe enough to seek medical opinion it is important to take them seriously and ask what self help has been tried before suggesting further non-pharmacological options or reassuring her that it is normal.	Thank you for this comment. The guideline committee have revised the recommendations to account for this.

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Pregnancy Sickness Support	Guideline	051	019-022	It is also important to discuss with women the risks of untreated (or undertreated) hyperemesis gravidarum and malnutrition for both her and the baby. There is plenty of evidence of the immediate and long term consequences for the offspring from first-trimester exposure to malnutrition. Additionally there is plenty of evidence of the biopsychosocial consequences for the mother. These risks, rather than the background risk of congenital malformations, should be discussed when deciding whether to take medication and which one.	Thank you for this comment. The text you're referring to has been revised but the point that we were trying to make is a more general comment around women's concern about taking medication during pregnancy. Based on the feedback from stakeholders the committee revisited the evidence and the draft recommendations for nausea and vomiting in pregnancy. The committee agreed that the review question was not aiming to cover comprehensive management of hyperemesis gravidarum but rather treatment for nausea and vomiting in pregnant women. Furthermore, most of the evidence on the more severe end of nausea and vomiting in pregnancy would actually not necessarily be considered hyperemesis gravidarum which is a very significant condition. The guideline generally does not address the management of severe conditions and the committee concluded that this is also the case for hyperemesis gravidarum. Therefore, the committee decided not to include anything specific about information provision for women with hyperemesis gravidarum although your point is valid.
Pregnancy	Guideline	051	022-024	While there may be some low quality evidence that ginger may help mild-moderate NVP, suggesting this can delay treatment of hyperemesis	Thank you for this comment. The guideline committee recommends trying ginger for the

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Sickness Support				gravidarum, which poses significant harm for a significant number of women. Furthermore, the RCTs used to evidence this suggest that ginger does not cause harm however, evidence these studies are heavily biased towards ginger and do not assess the very real harm caused in the professional-patient relationship caused by suggesting ginger at the point of seeking medical help. To be suggested ginger by a healthcare professional when seeking help for symptoms erodes trust and confidence as well as causing emotion harm and increased feelings of isolation. Women who contact our charity have coined the terms "to be gingered" referring to having one's symptoms dismissed by their healthcare professional. Furthermore there is evidence that ginger can exacerbate symptoms, increase acid reflux and is a painful substance to vomit. Please see reference: Dean CR, O'Hara ME. Ginger is ineffective for hyperemesis gravidarum, and causes harm: an internet based survey of sufferers. MIDIRS Midwifery Digest. 2015;25(4):449-55.	treatment of mild to moderate nausea and vomiting for those women who prefer a non-pharmacological option. The committee did not recommend ginger for more severe cases of nausea and vomiting during pregnancy. The evidence identified in this review on ginger did not show any evidence of harm on women with mild to moderate nausea and vomiting in pregnancy. The recommendations have been revised in line with other stakeholder comments, to account for those pregnant women who try various self-help approaches before seeking medical advice, and only present before a medical professional when it is serious. Thank you for providing this reference, which did not appear in our search strategy as it does not match the review protocol's inclusion criteria or the study design requirements for inclusion, and therefore the committee did not comment on this.
Pregnancy Sickness Support	Guideline	051	028-029	Acupressure is not effective for HG (beyond being able to demonstrate that you "have tried everything" to your mother-in-law!). You state is page 50 line 24 that no other non-pharmacological treatments are effective so	Thank you for this comment. There was moderate quality evidence from two studies that showed the effectiveness of acupressure plus

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				this recommendation is contradictory and confusing. Like with ginger, such suggestions can lead to delays of treatment and increased social-emotional harm among sufferers as well as an erosion of the patient-clinician trust.	standard care over sham acupressure plus standard care in women with severe nausea and vomiting. Based on the evidence the committee made this recommendation. The text you are referring to has now been removed based on the revisions to the recommendations. We appreciate it caused confusion.
Pregnancy Sickness Support	Guideline	051	009	This research recommendation has also been supported by a patient-clinician James Lind Alliance parternership for setting research priorities and is vitally important. Ref: Dean C., Bierma H., Clarke R., Cleary B., Ellis P., Gadsby R., et al. A Patient-Clinician James Lind Alliance Partnership to Identify Research Priorities for Hyperemesis Gravidarum. BMJ Open. 2021;11(1):e041254.	Thank you for this comment. Please note that the research recommendation was amended to cover severe nausea and vomiting in pregnancy and not only hyperemesis gravidarum. This change was made based on further discussion by the committee on the definition of hyperemesis gravidarum, recognising that there are cases of nausea and vomiting in pregnancy on the severe end of the spectrum which would not be considered to be hyperemesis gravidarum but for which steroids might be considered. Hyperemesis gravidarum, which is a very significant condition, was not considered to be within the scope of this guideline which covers routine antenatal care.

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Pregnancy Sickness Support	Guideline	052	011-013	"those prescribing medicines may need to spend more time discussing the options with the woman" – this would be a welcome change indeed if the discussion were to incorporate balanced discussion regarding the very real and serious risks of severe NVP and HG to both mum and baby and lack of curative treatment. Women would be helped massively if they were supported to understand that sometime medication in pregnancy is necessary and that they shouldn't feel guilty for requiring it. They should also feel reassured by the lack of evidence of any harm by these medications. We may not know which the most effective is by RCT data but there is substantial data that they are not causing harm, particularly when weighed against the harm of untreated HG and malnutrition.	Thank you for this comment. The guideline committee recommended having a discussion with the woman about the advantages and disadvantages of different antiemetics including taking into account her preferences and previous experiences, which supports informed and shared decision making. The evidence review looked at the harms of the medicines in terms of fetal or neonatal mortality, SGA and preterm birth. For other potential side-effects or risks, the committee signposted to the British National Formulary (BNF) information and the summaries of product characteristics (SPCs).
Pregnancy Sickness Support	Guideline	052	005-006	It is important to recognise that no evidence is not the same as 'it doesn't work'. You mention research in the area of corticosteroids but it is very little and of poor quality which significant heterogeneity. For example, non of the research where steroids were used assessed their efficacy in combination with antiemetics rather than in solo, or even documented where they were given in combination or alone – This is vitally important and current clinical practice thinking is that the steroids provide a boosting effect on the other antiemetics.	Thank you for this comment. We agree that no evidence does not mean it doesn't work, however, with no evidence to support its use and knowledge of adverse effects of corticosteroids, the guideline committee made no recommendation on the use of corticosteroids. There was no evidence identified on the effectiveness of corticosteroids in conjunction with antiemetics and so the committee could not comment on this. The

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				Additionally, where a woman feels the alternative to further treatment, such as with steroids, is to terminate an otherwise wanted baby then the benefits of trying them outweights the harm of not. You refer to "well known harms" of corticosteroids but are not explicit. Please provide clarity of these well known harms, particularly to the fetus and in the context of the harms of undertreated HG where termination is highly likely. Corticosteroids are used in pregnancy for a vast range of other conditions where the potential benefits are considered to outweight these "known harms", please provide context in relation to this specific condition.	evidence tables in Evidence review R gives details of which corticosteroids were given and what the comparator was in each of the 5 RCTs identified. The committee discussed that corticosteroids have well-known harms as documented in the BNF but that they are still used in the management of severe cases of nausea and vomiting. As a result of the current limited evidence and their knowledge about the use of corticosteroids, the committee made a research recommendation to inform future practice and guidance.
Prof Cathy Nelson-Piercy	Guideline	022	012	We are concerned that this recommendation may imply that ginger is effective for moderate NVP. It is not and furthermore may delay women's access to effective antiemetics. This is also at odds with the RCOG GTG on NVP / HG	Non-registered SH. No response required, however the point has been considered in finalising the guideline.
Prof Cathy Nelson-Piercy	Guideline	028	004	Acupressure is not effective for HG - please remove this line. We will remove it from the next iteration of the RCOG GTG This statement is also at odds with page 50 line 24 '*There was no evidence that any other non-pharmacological treatments are effective*'. NVP and HG are a continuum so it makes no sense that it would work at the more serious / severe end of the spectrum	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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Public Health Wales	Guideline	011	011 - 012	This link sends users to the Public Health England website. Users in Wales should be advised of the equivalent programmes in Wales and directed to the Public Health Wales / Antenatal Screening Wales programmes - https://phw.nhs.wales/services-and-teams/screening/antenatal-screening-wales/	Thank you for this comment. NICE guideline are developed for England so guidance for other devolved nations have not been included.
Public Health Wales	Guideline	011	03	This link sends users to the Public Health England website. Users in Wales should be advised of the equivalent programmes in Wales and directed to the Public Health Wales / Antenatal Screening Wales programmes - https://phw.nhs.wales/services-and-teams/screening/antenatal-screening-wales/	Thank you for this comment. NICE guideline are developed for England so guidance for other devolved nations have not been included.
Public Health Wales	Guideline	011	05	This link sends users to the Public Health England website. Users in Wales should be advised of the equivalent programmes in Wales and directed to the Public Health Wales / Antenatal Screening Wales programmes - https://phw.nhs.wales/services-and-teams/screening/antenatal-screening-wales/	Thank you for this comment. NICE guideline are developed for England so guidance for other devolved nations have not been included.
Public Health Wales	Guideline	011	06	This link sends users to the Public Health England website. Users in Wales should be advised of the equivalent programmes in Wales and directed to the Public Health Wales / Antenatal Screening Wales programmes - https://phw.nhs.wales/services-and-teams/screening/antenatal-screening-wales/	Thank you for this comment. NICE guideline are developed for England so guidance for other devolved nations have not been included.

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Public Health Wales	Guideline	011	015	This link sends users to the Public Health England website. Users in Wales should be advised of the equivalent programmes in Wales and directed to the Public Health Wales / Antenatal Screening Wales programmes - https://phw.nhs.wales/services-and-teams/screening/antenatal-screening-wales/	Thank you for this comment. NICE guideline are developed for England so guidance for other devolved nations have not been included.
Rebecca Middleton	Evidence review U -	General	General	Manual therapy (and mental health support) for all women needs to come as standard with a pelvic girdle pain (PGP) diagnosis. Exercises and support belts do not treat the underlying problem and in some cases, like mine, can significantly worsen the condition. For me, this resulted in an inability to function on a day to day basis (washing, dressing, feeding myself, walking etc) and an intolerable level of pain resulting in significant knock on effects for me physically, mentally and emotionally, to my family who had to watch me suffer, as well as the NHS in terms of subsequent costs. When I eventually got seen by an NHS physio, I was fobbed off and told I was "too severe" to treat which was rubbish because at the time I could actually walk (I later ended up in a wheelchair). I was told to exercise, use a support belt and crutches which did nothing but make everything worse (because I was pushing myself too hard and not listening to my pain as I later found out I should have been – a one size fits all set of guidelines is so dangerous and unhelpful with something as complex as PGP) and make me	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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				seriously depressed because I was doing everything I "could" and had been told to and the pain was increasing exponentially! Little did I know I had a problem which just needed to be treated with manual therapy. Luckily, I found a private practitioner via the Pelvic Partnership who saved me because at 30 weeks I was suicidal and done with pregnancy. My PGP traumatised me and I needed so much help both mentally and physically because I hadn't had the right treatment soon enough and my issues dragged on for many months after (not helped by lockdown where, for some reason now, NHS physios are rarely treating patients face to face where private physios like mine are). Not to mention the fact that I had to have a c section as a result of my severe PGP. I appreciate physios are an expensive and high demand resource but the knock on effects and cost to the NHS of all my subsequent issues were FAR greater than the cost of a physio would have been. Your report completely underplays how debilitating PGP is or how severe it can become and how much it affects women mentally too. I had two years of hell and if I'd have just had the right treatment when I went to the NHS in the first place, it wouldn't have been half as bad! It literally ruined my pregnancy and ruined my first 6+ months of life with my son, and I can never get that back! I very much hope you will reconsider. I wouldn't wish my pain and suffering on my worst enemy but reading this just makes me wish that someone in your organisation knew what it was really like even if	

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				just for a few seconds so you would take it A LOT more seriously. Finally, for me, the scariest thing is that by making it sound like manual therapy doesn't work, people wouldn't know about it or bother to pursue it privately (if they can afford to (sadly many cannot) or get charity funding). I implore you, at the very least, to acknowledge that it can be highly effective and even if the cost cannot be justified as part of your guidelines, women will know that there is something that can be done to help them and that they're not destined to never be able to walk or function again without pain. Of course I wish that everyone who needs it could get specialist physio for free on the NHS but if they cannot (because in my opinion the wider implications and costs have not been fully considered), at least acknowledge the effectiveness of manual therapy and help to educate and inform them because that is free! PS I'm sure you're well aware of information like this demonstrating how much sick leave is caused by PGP: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0667-0	
Royal College Obstetricians &	Guideline	050	015	Nausea and vomiting in pregnancy can be unpleasant, affect daily life and cause worry and upset.	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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Gynaecologists Greentop Guideline 69 Nausea & Vomiting in Pregnancy authorship group				This statement does not reflect the known and published severity of adverse quality of life impact. The RCOG CTG 69 outlines evidence of significant psychological morbidity which contributes to significant time off work and mental health issues.	
Royal College Obstetricians & Gynaecologists Greentop Guideline 69 Nausea & Vomiting in Pregnancy	Guideline	050	020	Some women prefer to use non-pharmacological treatments whereas others may 20 prefer pharmacological treatments, so both options are recommended. There is evidence that women find it difficult to access support and that health care professionals dismiss calls for help. We would suggest that this statement reads: Some women prefer to use non-pharmacological treatments whereas others may prefer pharmacological treatments and need to be supported, so both options are recommended. In severe cases with clinical signs of	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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authorship group				dehydration and metabolic disturbance, health care professionals should assess patients for specialist referral.	
Royal College Obstetricians & Gynaecologists Greentop Guideline 69 Nausea & Vomiting in Pregnancy authorship group	Guideline	050	022	We are concerned that this recommendation may imply that ginger is effective for moderate NVP. It is not and furthermore may delay women's access to effective antiemetics. This is also at odds with the RCOG GTG on NVP / HG	Non-registered SH. No response required, however the point has been considered in finalising the guideline.
Royal College Obstetricians & Gynaecologists Greentop Guideline 69	Guideline	051	025	Acupressure is not effective for HG - please remove this line. We will remove it from the next iteration of the RCOG GTG This statement is also at odds with page 50 line 24 '*There was no evidence that any other non-pharmacological treatments are effective*'. NVP and HG are a continuum so it makes no sense that it would work at the more serious / severe end of the spectrum	Non-registered SH. No response required, however the point has been considered in finalising the guideline.

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Nausea & Vomiting in Pregnancy authorship group					
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	General	General	There really should be a specific section on the woman's mental health in this guideline - just as there is a section for VTE and PV bleeding. The most recent MBRRACE report showed suicide is the 3rd biggest killer of pregnant women so there should be greater emphasis on this: even if it is just the specific questions that should be asked (Whooley questions) and how to refer on to a mental health specialist	Thank you for this comment. Instead of having it as a separate section, the committee decided to include antenatal mental health within the history taking section as it is an integral part of the basic discussion to be had with the woman. Reference to the NICE guideline on antenatal and postnatal mental health which covers the topic in more detail was made in this section and in other relevant sections of the guideline.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	General	General	This guidance looks very comprehensive.	Thank you.
Royal College of	Guideline	General	General	Suggest using 'A woman…' rather than 'The woman…' throughout.	Thank you for this comment. The guideline has been carefully edited by the NICE editors and

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Obstetricians and Gynaecologists (RCOG)					the most appropriate article to use depends on the context of the particular recommendation.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	General	General	There is promotion of the involvement of the partner in this draft, and also advice for the woman to be spoken to one on one so that she has the opportunity to reveal domestic abuse issues if they are present. By inviting the partner to all the appointments this makes it harder to achieve. Should NICE add a sentence about screening for domestic violence - consulting with the woman alone for one of the appointments? Domestic abuse in pregnancy is no doubt increasing during lockdowns, and an 'all partners welcome' approach risks letting an abusive partner into these appointments as default, which then puts the onus on the woman and maternity services staff to extract herself from the situation. There exist national resources to support health professionals around domestic abuse that could be signposted to at this stage of the document: https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals	Thank you for this comment. The guideline has a recommendation about enquiring about domestic abuse privately when the woman is alone. However, the committee agreed to revise the recommendation to clearly state that healthcare providers should ensure that there is an opportunity to discuss this privately on a one-to-one basis.
Royal College of Obstetricians and	Guideline	006	007	Is it worth adding a suggestion about how long the booking consultation should last e.g.20,30,40 minutes? The booking consultation is often the longest during the antenatal period.	Thank you for this comment. The committee agreed not to be prescriptive about the length of the appointments. This may also depend on individual circumstances, needs and risks

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Gynaecologists (RCOG)					identified during initial contact with the antenatal care services.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	006	023	"Ensure that reliable interpreting services are available if needed." Suggest clarifying that interpretation should not be offered by a member of the woman's family, guardian or partner, as specified in NICE Guideline CG110 (Pregnancy and complex social factors) which states - "Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language". This recommendation is also highlighted several times in the latest MBRRACE-UK report. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10.pdf	Thank you for this comment. We have revised the wording so that it is clear that the interpreter should be independent of the woman.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	007	General	Classes, or classes and appointments?	Thank you for this comment. This has been amended as suggested to 'classes and appointments'.
Royal College of Obstetric	Guideline	007	010	Displaying positive images of partner involvement – what evidence is there that this helps improve partner engagement?	Thank you for this comment. There was evidence from one study, from a male partner who felt hesitant to share his opinions, which was prompted by external stimuli in the

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ians and Gynaecologists (RCOG)					antenatal setting. He felt that posters about domestic abuse influenced the consultation style, where he felt it was assumed that he conformed to a stereotype. The committee agreed that domestic abuse is a prevalent public health issue and that the woman's safety is paramount so it is important to have those messages in antenatal clinics in order to raise awareness about domestic abuse and possibly lower the threshold for women or male partners to discuss it in antenatal appointments. However, the committee agreed that it is also important to have positive messages and imagery about caring partners in these spaces in order to avoid stereotypes and facilitate involvement of partners who are men.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	8	004	Physical activity – this is mentioned without specifics as to what the woman is advised. NHS advice is 150 mins/week suggest signposting to this?	Thank you for this comment. The recommendation you are referring is about asking her about her current physical activity. Information provision about physical activity is covered by another section of the guideline where a reference to the NICE guideline weight management before, during and after pregnancy is made which covers physical activity.
Royal College	Guideline	008	021	In the deprived category it is x 2.5 more likely not x 3. Unless the associated confidence interval suggests otherwise.	Thank you for this comment. The recommendation has been revised accordingly.

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of Obstetricians and Gynaecologists (RCOG)					
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	9	008–009	(brackets) – there is a developers comment to be removed. I personally do not think the order is relevant.	Thank you, we have removed the text in brackets which was left accidentally.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	009	027	Does the woman have to consent to information being shared with her GP? If so, this recommendation implies that this will be checked and agreed to without specifying.	Thank you for this comment. The committee amended the wording to say this should be discussed and agreed with the woman.
Royal College of Obstetricians and	Guideline	011	019	Anti D....add the alternative option to anti D for all = free fetal DNA prediction	Thank you for this comment. We have added a reference to the NICE diagnostic guideline on high-throughput non-invasive prenatal testing for fetal RHD genotype which covers this.

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Gynaecologists (RCOG)					
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	012	012	Appropriate care for women at increased risk of VTE is to start thromboprophylaxis not refer to an obstetrician. This can easily be facilitated within the community midwifery setting without the need for hospital referral as per risk assessment from RCOG VTE guidelines	Thank you for this comment. The committee agreed that prescribing thromboprophylaxis is not in the remit of most midwives and a referral would be needed.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	013	002	NICE should consider the results of the implementation of routine first trimester combined screening for pre-eclampsia study: https://doi.org/10.1111/1471-0528.16361 This study demonstrated a reduction in rates of pre-eclampsia by 25%with particular benefits in the early onset pre-eclampsia group. The study demonstrated that first trimester screening could be performed in the NHS without any additional resource. Recommendations for screening for PET should include assessment of PAPP-a and maternal uterine artery Doppler as part of an algorithm to identify high risk women. This would reduce the % of women taking aspirin in the population while improving the detection rate of the at risk individuals.	Thank you for this comment. Screening for pre-eclampsia was not in the scope for this guideline and thus the study referenced has not been considered.
Royal College of	Guideline	014	012	Baby large? I think this is too specific. Further assessment by ultrasound would also be indicated if SFH measures large secondary to	Thank you for this comment. We have revised the wording in the recommendation to not assume the baby is large but rather that when

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Obstetricians and Gynaecologists (RCOG)				polyhydramnios. The combination of a small baby and high liquor volume would be of more concern and not picked up by this recommendation. I suggest the nature of the suspicious abnormalities of having a higher than expected SFH is broadened, and that the action following looks at fetal biometry, and a check of LV or Doppler etc as indicated rather than just fetal growth, or more accurately fetal size.	the SFH is large for gestational age, ultrasound scan should be considered for fetal growth and wellbeing.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	014	015	The text here isn't helpful for midwives who are uncertain of the timescale when referral should take place. In the situation where there is lack of evidence to guide this an expert opinion should be provided: eg on the same day of there is a history of reduced fetal movement; within 2-3 working days if not etc. There should also be guidance regarding the gestational age when this is relevant eg at 22 weeks. Should the SFH be plotted? And where? And what action should be taken where the baby crosses centiles on the chart?	Thank you for this comment. The committee discussed that this did not appear to be an issue for the stakeholders representing midwives and the clinical judgement of midwives should be sufficient to determine the urgency. The recommendations state that SFH measurements should start from 24 weeks onwards. The committee agreed to add that SFH should be plotted onto a growth chart. Further management beyond ultrasound scan when the baby is considered to be small for gestational age is not covered by this guideline on routine antenatal care.
Royal College of Obstetricians and	Guideline	015	019-020	"explain to women that turning the baby from a breech to a head down 20 position makes a normal, head-first vaginal birth more likely" Suggest removal of the word "normal" to avoid unnecessarily value-laden terminology.	Thank you for this comment. We agree with this comment, however, this section was revised and that sentence was removed.

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Gynaecologists (RCOG)					
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	015	015	When should this scan be- bearing in mind that It is more difficult to perform an ECV the closer to 39 weeks you are? Ultrasound is also performed to ascertain if there is a reason for the breech presentation.	Thank you for this comment. The committee did not review evidence on the exact time ECV should be performed so this has not been commented on.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	015	015	The use of 'confirm it' implies that the presentation will be proven to be breech. If palpation suggests breech then "Presentation should be formally assessed with a timely ultrasound". As the next recommendation also says the ECV should be offered in most cases, it is worth saying that if breech presentation is confirmed on ultrasound, then the ultrasound should assess fetal size, placental site and LV, as these may be discover relative or absolute contraindications to ECV.	Thank you for this comment. We have revised the wording in the recommendation slightly, however, the committee did not make a more detailed recommendation about the ultrasound. The committee discussed that presentation scans are more available than full growth scans and for example placental site should already be known at this stage.
Royal College of Obstetricians and Gynaecol	Guideline	015	017	I think this recommendation is slightly misleading. Saying that 'ECV making cephalic vaginal birth more likely' is intrinsic to the nature of the procedure, the fact it is recommended at all, and its efficacy. Without ECV the chances of a cephalic vaginal birth would require spontaneous reversion and then spontaneous onset of labour.	Thank you for this comment. The recommendation has been revised and this sentence has been removed.

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ogists (RCOG)				The more relevant comparison is of a woman declining ECV and then having a vaginal breech birth, which is also the much more likely outcome compared to spontaneous version and labour. There are advantages to ECV and cephalic vaginal birth for the mother and the baby in my view – and the idea to recommend to the low risk woman with a breech presentation at 36+0, is one I agree with - the recommendation as it stands does not reflect these in a fair way.	
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	016	008	Here one to one is recommended. This goes against many of the other recommendations where involvement of the birth partners is promoted. Does one to one here mean just the woman, or the woman and her partner?	Thank you for this comment, we have revised the wording. We meant woman and her partner, if present.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	016	011	Insert a specific sentence about translation services for non-English speaking women	Thank you for this comment. Translation/interpretation services have already been covered in the recommendation.
Royal College	Guideline	017	013	Also consider inclusion for deaf, blind, and those with learning difficulties/intellectual impairment–	Thank you for this comment. This recommendation refers to a specific NICE

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of Obstetricians and Gynaecologists (RCOG)					guideline which covers particular groups of women who may need additional support. In order to avoid further confusion, we have revised the wording in the recommendation and moved the recommendation to a more appropriate section in the guideline. Otherwise, any additional support based on medical, social or emotional reasons are covered by other recommendations earlier in the guideline.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	018	004	Should also cover COVID advice in this section. Vaccination advice for COVID. Identifying at risk groups eg Black, Asian and minority ethnic women	Thank you for this comment. Immunisation for COVID has been added as an example.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	019	012	"discuss and give information on: ... the results of any blood or screening tests from previous appointments." Consider linking to Royal College of Obstetricians and Gynaecologists, Royal College of Midwives and Society and College of Radiographers consensus statement on supporting women and their partners through prenatal screening for Down's syndrome, Edwards' syndrome and Patau's syndrome, published in advance of the NIPT roll-out in NHS England. This has important information for medical professionals involved in prenatal	Thank you for this comment. NICE generally does not refer to resources that have not been accredited by NICE which is the case for this statement, therefore, no reference has been made.

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				screening and links to e-learning resources and resources for women and their families. This resource could alternatively be referenced in the Examinations and investigations section.	
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	021	006	Does this cover if a woman is parous, has a new partner, and the current partner has never been involved in a pregnancy before?	Thank you for this comment. Yes, if it would be considered beneficial.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	021	015	Peer support - is it worth adding some examples of peer support?	Thank you for this comment. The committee agreed not to add examples of types of peer support because the committee did not review evidence on the effectiveness of different types of peer support and there may be various different types and highlighting some over others without evidence of benefit was not considered helpful.
Royal College of Obstetricians and Gynaecol	Guideline	022	005	Add a specific recommendation about left lateral sleeping rather than just avoiding sleeping on back.	Thank you for this comment. This is not what the evidence suggests, there was no risk associated with right lateral compared to left lateral.

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ogists (RCOG)					
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	022	011	Is the ginger oral, capsule, in tea, all of the above, or nibbling on root ginger?	Thank you for this comment. From the 9 studies investigating the effectiveness of ginger, 7 used oral ginger tablets, 1 used ginger syrup, and 1 used ginger biscuits. The committee agreed not to be specific about the form of ginger because evidence review did not look into the most effective format.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	025	Table 1	Metoclopramide – Is the risk of extra pyramidal side effects also relevant for the mother?	Thank you for this comment. Yes, this was perhaps slightly ambiguous in the text and this has been revised.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	025	Table 1	Ondansetron – can remove the word 'even' from the rationale ' ...~~even~~ with ondansetron 9,986 of...". Ondansetron – there is a recognised side effect of constipation for the mother - this may be particularly useful to highlight given reduced oral and liquid intake in the affected mothers.	Thank you, this wording has been amended as suggested. In terms of other side effects, we have advised to refer to the BNF or SPCs and have not added this level of detail to the table.

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Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	029	005	I'm not quite sure why we're recommending antibiotics for bacterial vaginosis in pregnancy as I am not aware that adversely affects either mother or baby. If it's only for symptomatic relief, then suggest that that is stated.	Thank you for this comment. Yes, the committee made a weak 'consider' recommendation because symptom relief via antibiotics might be appropriate, this section only covers symptomatic vaginal discharge.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	030	009	As well as ultrasound scan for placental location, RCOG recommend serial growth scans for PVB in pregnancy as per GTG for small for gestational age babies	Thank you for this comment. The scope of the guideline did not include the further management when there is unexplained vaginal bleeding therefore this has not been commented on.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	030	010	The RCOG Green-top Guideline on antenatal corticosteroids is currently in final stages of publication and has a tentative publication date around late June/early July This can be provided once published.	Thank you for this information.
Royal College of	Guideline	032	General	The guideline recognises the disparities in outcome for women and babies from Black, Asian and minority ethnic backgrounds and those living in deprived areas, and explanatory notes mention that "future research could	Thank you for this comment. We agree that research on this is needed, however, we are only able to make research recommendations on

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Obstetricians and Gynaecologists (RCOG)				help understand the mechanisms underlying these disparities and what interventions could improve the outcomes". Although research recommendation 3 – should different models of antenatal care be used for groups at risk of worse outcomes – refers to this issue, we suggest a key recommendation addressing the disparities in outcome specifically would more sufficiently reflect the urgent need for further research in this area.	topics we have specifically tried to identify and review evidence on, therefore, no particular research recommendation has been made on this topic, although as you say, the committee wanted to address this in the research recommendation about the different models for antenatal care.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	050	001-003	It's not clear what sleeping position should be maintained.	Thank you for this comment, we have slightly amended the wording so hopefully it's clearer now, the recommendation is avoid supine position, not to sleep in a particular position.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	050	020-021	Is it because of maternal preference that both options are recommended?	Thank you for this comment. Both options are recommended based on the committee's knowledge and the evidence. There was some evidence that ginger is effective in treating mild to moderate nausea and vomiting in pregnancy compared with placebo, and this may be an option particularly for women who want to try a non-pharmacological option. There was also evidence on a wide variety of pharmacological treatments, which varied in quality and for some

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					medicines no evidence was found. From their knowledge and experience, the committee discussed that some women preferred to try a non-pharmacological option, whilst for some women pharmacological options is the preferred choice, or they have already tried non-pharmacological options before seeking medical advice.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	051	010-22	The writing is clunky. Delete 'All of' at the start of the para.' Are lines 19-22 striking the right balance – one might go for informing the patient of the quality of evidence for absence of adverse effect of the medication rather than appearing to mount an advance defence against a suggestion that the medication was associated with an adverse outcome. 'Discuss' is used x2 in line 19.	Thank you for this comment, we have revised the text based on your suggestions.
Royal College of Paediatrics and Child Health	Guideline	General	General	Consider referring information given antenatally about the newborn screening tests. 'Screening tests for you and your baby' PHE information www.gov.uk/phe/pregnancy-newborn-screening.	Thank you for this comment. The committee have revised the recommendations to be more specific that information about screening programmes should be given and discussed in order to enable informed decision making. We have not made references to any specific information sources.
Royal College of Paediatri	Guideline	General	General	The reviewer acknowledged that the guideline flows wells and is very informative, however, it was noted that the guideline will not make many changes to the current practice as it can be quite self-explanatory.	Thank you for this feedback.

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cs and Child Health					
Royal College of Paediatrics and Child Health	Guideline	General	General	It was suggested that face to face vs virtual appointments for antenatal care should be addressed in the guideline.	Thank you for this comment. Virtual appointments was not include in the scope for this guideline, the scope was developed in 2019. Virtual appointments have of course become much more prominent in recent times and evidence on their benefits and harms continue to emerge in the future. However, this type of evidence was not reviewed by the committee and is therefore not commented on. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Royal College of Paediatrics and Child Health	Guideline	General	General	The reviewer noted that this is no mention if something abnormal is found, clarification on whether this would be referred to foetal anomaly clinic would be beneficial.	Thank you for this comment. The committee agreed to add a recommendation that if anything unexpected is found in any of the screening or other examinations and investigations, referral should be made according to local pathways.
Royal College of Paediatrics and	Guideline	011-016	General	There should be a separate section, in line with those for venous thromboembolism, gestational diabetes etc, which recommends the information required to give to women about the risk of preterm birth, and the potential for the baby to require specialist neonatal care, basic	Thank you for this comment. Preterm birth as such is not in the scope of this guideline and is covered by the NICE guideline on preterm labour and birth which we have now added a reference to in the antenatal care guideline. Furthermore,

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Child Health				information about neonatal networked care and in utero and ex utero transfer of care, signs of symptoms of threatened preterm labour and what to do in the event of this. This is massively important if there is going to be a joined up approach to reducing preterm birth from 8% to 6% and produce the required national reduction in perinatal mortality and brain injury.	the committee have added a recommendation to the section on unexplained vaginal bleeding about considering discussing the increased risk of preterm birth with women who have unexplained vaginal bleeding.
Royal College of Paediatrics and Child Health	Guideline	008-010	General	There is no mention of screening for increased risk of preterm birth, including previous preterm delivery, cervical surgery, previous CS at full dilatation etc. This must be included to ensure information is given to women about potential risks of preterm birth, potential for need for neonatal specialist care, referral to high risk clinics. This will help ensure appropriate interventions to reduce preterm birth in line with the Saving Babies Lives Care Bundle version 2 and reducing perinatal mortality and brain injury in line with the NHS Long Term Plan.	Thank you for this comment. Screening for preterm birth is in the remit of the UK National Screening Committee and currently national screening is not recommended.
Royal College of Paediatrics and Child Health	Guideline	016	016	Communication with deaf people (mothers and their partners and supporters) especially at times when personal protective equipment is worn can prove difficult. The workforce needs always to be aware that many deaf people rely very much on lipreading and therefore the type of PPE used must be taken into consideration. Sometimes the use of a British Sign language interpreter may be more appropriate.	Thank you for this comment, we have added British Sign Language to the recommendation to highlight this.
Royal Pharmaceutical Society	Guideline	024	General	Metoclopramide is stated to be 'established practice as second-line treatment in pregnancy', but none of the other antiemetic options are given a stepwise place in therapy. Is there a preferred step-wise treatment	Thank you for this comment. Based on the evidence, the committee were not able to recommend a step-wise approach. The guideline

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				approach for the use of anti-emetics? If not, would the choice of antiemetic be guided by the antenatal team?	recommends that healthcare professionals use the table provided to aid the discussion and shared decision making on the preferred choice of an antiemetic.
Royal Pharmaceutical Society	Guideline	028	001-003	The draft guideline does not mention the use of thiamine for pregnant women with hyperemesis gravidarum but does give recommendations for intravenous fluids and antiemetics in these women. Please could you clarify the role or place of therapy of thiamine in the management of hyperemesis gravidarum. We are aware that the RCOG guidelines: *Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum (Green-top Guideline No. 69)* (available at: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg69/) do recommend thiamine supplementation (oral or intravenous) for pregnant women with prolonged vomiting to prevent complications that can occur with hyperemesis gravidarum.	Thank you for this comment which the committee considered at length. The committee revisited the evidence and the draft recommendations in light of your and other stakeholders' comments. The committee agreed that the review question was not aiming to cover comprehensive management of hyperemesis gravidarum including interventions for malnutrition, although the evidence review included women with hyperemesis gravidarum as well. Most of the evidence on the more severe end of nausea and vomiting in pregnancy would actually not necessarily be considered hyperemesis gravidarum which is a very significant condition. The guideline generally does not address the management of severe conditions and the committee concluded that this is also the case for hyperemesis gravidarum. Therefore, the committee decided to revise the

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					wording in the recommendations and the evidence report so that instead of referring to 'hyperemesis gravidarum', the guideline now refers to 'moderate to severe nausea and vomiting in pregnancy'. The committee also added a recommendation that when the nausea and vomiting is so severe that it cannot be managed with treatments available from the primary/outpatient care (this would include women with hyperemesis gravidarum), inpatient care should considered.
Slimming World	Guideline	010	008-015	We feel it's important that there are stronger recommendations surrounding weighing women during antenatal appointments to allow for monitoring of gestational weight gain. Currently the guideline links through to the PH27 (weight management before, during and after pregnancy) which specifies not to routinely weigh women. We'd suggest that the advice on weighing women is reconsidered and that it be recommended that women be weighed at each antenatal appointment as standard. This would allow for identification of weight changes which may be a concern – identifying those women who are losing	Thank you for this comment. Weight monitoring and management is not in the scope of this guideline and therefore evidence on it has not been reviewed and further recommendations have not been made. The referenced study may be more relevant to the remit of the NICE guideline PH27 on weight management before, during and after pregnancy which is currently being updated.

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				weight/gaining too little weight and those who are gaining 'excess' weight – both of which increases the risk of complications for the woman and baby. More emphasis on the prevention of excess weight gain/appropriate weight gain during pregnancy and routine antenatal weighing will allow better monitoring of women and help inform appropriate gestational weight gain guidelines for the UK. We'd like to highlight a recently published study which identified that routine weighing of women was seen as acceptable to pregnant women, in fact many found it a positive experience and indicated that they would appreciate more information and support about weight during pregnancy. https://pubmed.ncbi.nlm.nih.gov/32471375/.	
Society and College of Radiographers	General	General	General	**EVIDENCE OF SIMILAR EFFECTS TO USUAL CARE, AND OF PREVENTION OF LOW BACK PAIN OR PELVIC GIRDLE PAIN** **Comment 12** Preliminary observation of the studies identified indicates that manual therapy / osteopathic manipulation may be of equivalent benefit to usual	Thank you for this comment. Hall 2016 was identified by our search but not included in the review. As it is a systematic review, we checked their included studies, but they do not meet the criteria set out in the protocol so they were not included in the review. The committee has not made a recommendation for osteopathy for pelvic girdle pain as there was no evidence to support a recommendation. Please see the

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				care[1], and as such should be acknowledged by the NICE guidelines as **potentially providing an increased opportunity for care if patients were to be referred for osteopathy services**. We recommend that the additional data identified in this report be analysed to evaluate the possible benefits of including osteopathic care as an additional service stream to physiotherapy services.	'Committee discussion of the evidence' section of evidence review U for more detail.
Society and College of Radiographers	Additional questions	General	General	1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Additional scans for LGA babies may impact on the already stretched ultrasound services. There is currently a national shortage of sonographers. Further increasing the number of scans being offered will put additional strain on the service.	Thank you for this comment. This recommendation is a 'consider' recommendation due to limited evidence so the expectation is not that there will be a huge increase in demand. However, we have noted this potential impact in the 'How the recommendations might affect practice' section. .
Society and College of Radiographers	Additional questions	General	General	2. Would implementation of any of the draft recommendations have significant cost implications? Additional scans for LGA babies will potentially be costly, both financially and in relation to the limited resources available for ultrasound scans.	Thank you for this comment. The recommendation is to 'consider' scans when symphysis fundal height measurement is large for gestational age, so increase in scans for this indication is not expected to be large. That being said, all recommendations are made with explicit consideration given to cost effectiveness. These discussions, and anticipated impact on resource

[1] Hall H, Cramer H, Sundberg T, Ward L, Adams J, Moore C, Sibbritt D, Lauche R. The effectiveness of complementary manual therapies for pregnancy-related back and pelvic pain: A systematic review with meta-analysis. Medicine (Baltimore). 2016 Sep;95(38):e4723. doi: 10.1097/MD.0000000000004723. PMID: 27661020; PMCID: PMC5044890.

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					use are documented in the cost effectiveness and resource use sections of the relevant evidence reviews. NICE also produce a Costing Report considering the overall resource impact of implementing the guideline.
Society and College of Radiographers	Additional questions	General	General	3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Educational funding (and associated backfill costs) to train further sonographers to undertake the ultrasound examinations Consideration for the care of LGBTQ+ patients in the antenatal care pathway to provide a streamlined process to support them during their pregnancy.	Thank you for this comment. There is not an expectation that there will be a big increase in the need for ultrasound scans based on the recommendations. In fact in some areas there may be a decrease in the number of scans because the guideline specifically advises against routine ultrasound scan for low risk pregnancies, which in some areas happen. However, thank you for flagging this. We have added this to the 'How the recommendations might affect practice' section in relation to recommendations on 'Monitoring fetal growth and wellbeing'. Regarding LGBTQ+ expectant parents, thank you for flagging this issue. The committee has carefully thought about the inclusiveness of the guideline and how it applies to people in different situations. Tailoring antenatal care, partner involvement and general communication, information provision and support should be based on the individual needs and preferences, which is fundamental part of delivering good antenatal service. The committee has aimed to

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					capture this in the recommendations. We have flagged this in the equality impact assessment as well.
Society and College of Radiographers	Additional questions	General	General	4. The recommendations in this guideline were developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication Increasing aggression towards health care professionals in maternity. In ultrasound this is particularly around the filming / videoconferencing of the scan, which is an extremely complex clinical examination. Teleconferencing would support discussions without adding to the pressures sonographers face during the examination.	Thank you for this comment. We understand the concern around filming during a scan, however, this issue is something to be managed through local arrangements.
Society and College of Radiographers	Guideline	006	023	The SCoR would recommend clarifying that this should be available for all encounters, so that it encapsulates ultrasound examinations. This would ensure that the ultrasound department are made aware of the need for an interpreter, at the time of booking the appointment.	Thank you for this comment. We have clarified this in the 'Why the committee made the recommendations' section.
Society and College of Radiographers	Guideline	007	021	In relation to the statement 'considering opportunities for virtual attendance' the SCoR would recommend clarification e.g. considering opportunities for virtual attendance, where feasible, when a partner is unable to attend an appointment and the woman/pregnant person needs additional support. This might be via teleconferencing.	Thank you for this comment. We have revised the wording in the recommendation to clarify this is about partner's attendance and only when appropriate.

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Society and College of Radiographers	Guideline	014	012 - 015	Is it possible for NICE to define "concerns" for large for gestational age (LGA) and small for gestational age (SGA) by fundal height. Eg. More than 3cms difference from expected fundal height for gestational age? This would be helpful for ultrasound departments enabling them to prioritising their workload.	Thank you for this comment. The committee discussed this at length during the development of the guideline was concluded that given the evidence that was reviewed, they were not able to give more detailed guidance on what the cut-offs for concern would be.
Society and College of Radiographers	Guideline	014	012	The evidence for recommending ultrasound for LGA babies seems limited. The implications of both cost and capacity are of concern, based on this limited evidence.	Thank you for this comment. For all the recommendations the committee considered the potential resource and cost implications and this has particular issue has now been acknowledged in the 'How the recommendations might affect practice'. This recommendation is a 'consider' recommendation due to limited evidence so the expectation is not that there will be a huge increase in demand.
Society and College of Radiographers	Guideline	032	006	Doppler should have a capital letter.	Thank you for this comment. NICE style is to write doppler with a lower case d.
Society for osteopathic	Appendix K	General	General	**EXCLUDED RESEARCH** In Appendix K there is a list of excluded studies. The reasons for exclusion are listed alongside the title of the paper. Some are listed as being a	Thank you for this comment and the suggestion to include Franke et al. As this is a systematic review we have checked the studies that have been included in this review. However, the included studies in this review do not meet the

<table>
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<tr><td>healthcare</td><td></td><td></td><td></td><td>journal article only, implying that the actual research is not available for appraisal.

Comment 9
We are surprised to see the paper by Franke et al[2] being excluded as it was apparently only available as an abstract. This is concerning as this paper is freely available as a full text article, and as it is a systematic review and a meta analysis it should have met the inclusion criteria and so have been analysed. We feel this is a significant oversight which should be addressed. The full text link is here:
https://core.ac.uk/download/pdf/154925175.pdf
The summary of this review is included below.

<table>
<tr><th>STUDY</th><th>ABSTRACT</th></tr>
<tr><td>Osteopathic manipulative treatment for low back and pelvic girdle pain during and after pregnancy: A systematic review and meta-analysis</td><td>Background: To examine the effectiveness of osteopat
treatment (OMT) for low back pain (LBP) in pregnant o
Methods: Randomized controlled trials unrestricted by
reviewed. Outcomes were pain and functional status. N
standard mean difference (SMD) and overall effect size
Results: Of 102 studies, 5 examined OMT for LBP in pr
postpartum LBP. Moderate-quality evidence suggested
medium-sized effect on decreasing pain (MD, -16.65) a
status (SMD, -0.50) in pregnant women with LBP. Low-
suggested OMT had a significant moderate-sized effec
(MD, -38.00) and increasing functional status (SMD, -2</td></tr>
</table>
</td><td>criteria set out in our protocol so they have not been included in our review.</td></tr>
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				women with LBP. Conclusions: **This review suggests OMT produces clinically relevant benefits for pregnant or postpartum women with LBP.** Further research may change estimates of effect, and larger, high-quality randomized controlled trials with robust comparison groups are recommended. **Table above in text only form:** STUDY ABSTRACT Osteopathic manipulative treatment for low back and pelvic girdle pain during and after pregnancy: A systematic review and meta-analysis Background: To examine the effectiveness of osteopathic manipulative treatment (OMT) for low back pain (LBP) in pregnant or postpartum women. Methods: Randomized controlled trials unrestricted by language were reviewed. Outcomes were pain and functional status. Mean difference (MD) or standard mean difference (SMD) and overall effect size were calculated. Results: Of 102 studies, 5 examined OMT for LBP in pregnancy and 3 for postpartum LBP. Moderate-quality evidence suggested OMT had a significant medium-sized effect on decreasing pain (MD, -16.65) and increasing functional status (SMD, -0.50) in pregnant women with LBP. Low-quality evidence suggested OMT had a significant moderate-sized effect on decreasing pain (MD, -38.00) and increasing functional status (SMD, -2.12) in postpartum women with LBP. Conclusions: This review suggests OMT produces clinically relevant benefits for pregnant or postpartum women with LBP. Further research may change estimates of effect, and larger, high-quality randomized controlled trials with robust comparison groups are recommended.	

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				This paper has a number of findings, and as the search was conducted in a more recent time frame and included a wider inclusive literature capture strategy (as recommended by Cochrane) **we believe its finding should supersede those of other reviews**, which do not find evidence in support of manual therapy and / or osteopathy for pelvic girdle pain or low back pain.	
Society for osteopathic healthcare	Evidence review U	General	General	**LITERATURE SEARCHES** *Appendix B – Literature search strategies Literature search strategies for review question: What interventions are effective in treating mild to moderate pelvic girdle pain during pregnancy?* **COMMENTS ON SEARCH STRATEGIES:** The PICO review was as follows: (page 6: https://www.nice.org.uk/guidance/GID-NG10096/documents/evidence-review-12)	Thank you for this comment. The literature search focused on the population and condition (pregnancy and pelvic girdle pain), using MeSH headings, textwords, synonyms and associated conditions as felt relevant – it did not exclude any type of intervention nor any staff that provided those interventions. Focusing on population and condition resulted in a wider search and screening more evidence, whereby searching for specific interventions such as manual therapy (using MeSH headings and textwords) was unnecessary.

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				12 **Summary of the protocol** 13 Please see Table 1 for a summary of the Population, Intervention, Comparison and Outcom 14 (PICO) characteristics of this review. 15 **Table 1: Summary of the protocol (PICO table)** **Population**: Pregnant women with mild to moderate pelvic girdle pain **Intervention**: • Acupuncture/Acupressure exercises • Analgesics - only opiates and paracetamol will be considere • Ice packs and heat packs • Manual therapy • Pelvic girdle support • Physiotherapy-delivered advice • Pillow • Reflexology **Comparison**: • No treatment • Any other intervention listed above **Outcomes**: **Critical outcomes** • Pain intensity (pain levels) during pregnancy (pain intensity during labour or birth will not be considered) • Pelvic-related functional disability/functional status during pregnancy (such as ability to perform daily activities) **Important outcomes** • Adverse effects during pregnancy • Days off work/sick leave (during pregnancy or prior to mater leave) • Days in hospital admitted to antenatal ward for treatment of pelvic girdle pain (exclude admission for labour or early labo • Women's experience and satisfaction • Admission at birth to the neonatal unit 16 For further details, see the review protocol in appendix A.	

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				Comment 5 The search strategies should have included various MeSH headings, and the term manual therapy, as this is an included intervention of interest in the PICO. Mesh headings of value, which don't appear to have been used:	
Society for osteopathic healthcare	Evidence review U	General	General	**Comment 6:** ISOHC was only able to utilise a search of free online databases when preparing this report. Search of Pubmed, using terms 'pregnancy' and 'manual therapy' revealed 1284 results, 25/3/21. 61 of these are meta analyses. 209 were randomised controlled trials. 116 were systematic reviews. 10 of these were highly relevant to manual therapy and low back pain and pelvic girdle pain management in pregnancy. 9 of these were not detected in your searches – or at least have not been included in the included or excluded lists. **We believe this is a significant omission which should be address, and we believe these papers should be analysed.** One of the papers was a systematic review and meta analysis which you excluded as it was an abstract only – we deal with this below. The list of the 10 papers found through this simple search are: 1. The effectiveness of complementary manual therapies for pregnancy-related back and pelvic pain: A systematic review with meta-analysis.	Thank you for this comment and the list of references you have provided. The literature search focused on the population and condition thereby identifying any relevant intervention used for pelvic girdle pain. The references you have provided have been checked against criteria set in the review protocol. None of them fit the criteria and have not been included in the review. Reasons for exclusion are: Hall 2016, Liddle 2015, Franke 2017, Ruffini 2016, Van Benten 2014, Khorson 2009, Stuber 2008 - these references are systematic reviews so their included studies have been checked but do not meet our protocol criteria so cannot be included. Pennick 2013 - this is an earlier reference of Liddle 2015. Liddle 2015 is the more recent review and all included studies in Pennick. 2013

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				Hall H, Cramer H, Sundberg T, Ward L, Adams J, Moore C, Sibbritt D, Lauche R. Medicine (Baltimore). 2016 Sep;95(38):e4723. doi: 10.1097/MD.0000000000004723. PMID: 27661020 **Free PMC article.** Review. 2. Interventions for preventing and treating low-back and pelvic pain during pregnancy. Liddle SD, Pennick V. Cochrane Database Syst Rev. 2015 Sep 30;2015(9):CD001139. doi: 10.1002/14651858.CD001139.pub4. PMID: 26422811 **Free PMC article.** Review. 3. Osteopathic manipulative treatment for low back and pelvic girdle pain during and after pregnancy: A systematic review and meta-analysis. Franke H, Franke JD, Belz S, Fryer G. J Bodyw Mov Ther. 2017 Oct;21(4):752-762. doi: 10.1016/j.jbmt.2017.05.014. Epub 2017 May 31. PMID: 29037623 Review. 4. Osteopathic manipulative treatment in gynecology and obstetrics: A systematic review. Ruffini N, D'Alessandro G, Cardinali L, Frondaroli F, Cerritelli F. Complement Ther Med. 2016 Jun;26:72-8. doi: 10.1016/j.ctim.2016.03.005. Epub 2016 Mar 7. PMID: 27261985 Review. 5. Interventions for preventing and treating pelvic and back pain in pregnancy.	have been considered when addressing Liddle 2015. Weis 2020 - the reference for this was added to search databases after the final literature searches were run, but we have checked the included studies. This is a systematic review and 3 of the included studies were included in our review. The others did not meet our protocol criteria so cannot be included. Koukoulithras 2021 - the reference for this was added to the search databases after the final literature searches were run. However, this is a systematic review looking at women with low back pain and not specific to pelvic girdle pain.

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				Pennick V, Liddle SD. Cochrane Database Syst Rev. 2013 Aug 1;(8):CD001139. doi: 10.1002/14651858.CD001139.pub3. PMID: 23904227 Updated. Review. 6. Recommendations for physical therapists on the treatment of lumbopelvic pain during pregnancy: a systematic review. van Benten E, Pool J, Mens J, Pool-Goudzwaard A. J Orthop Sports Phys Ther. 2014 Jul;44(7):464-73, A1-15. doi: 10.2519/jospt.2014.5098. Epub 2014 May 10. PMID: 24816503 Review. 7. Manipulative therapy for pregnancy and related conditions: a systematic review. Khorsan R, Hawk C, Lisi AJ, Kizhakkeveettil A. Obstet Gynecol Surv. 2009 Jun;64(6):416-27. doi: 10.1097/OGX.0b013e31819f9ddf. PMID: 19445815 Review. 8. Chiropractic Care for Adults With Pregnancy-Related Low Back, Pelvic Girdle Pain, or Combination Pain: A Systematic Review. Weis CA, Pohlman K, Draper C, daSilva-Oolup S, Stuber K, Hawk C. J Manipulative Physiol Ther. 2020 Sep;43(7):714-731. doi: 10.1016/j.jmpt.2020.05.005. Epub 2020 Sep 6. PMID: 32900544 Review. 9. Chiropractic treatment of pregnancy-related low back pain: a systematic review of the evidence. Stuber KJ, Smith DL. J Manipulative Physiol Ther. 2008 Jul-Aug;31(6):447-54. doi: 10.1016/j.jmpt.2008.06.009.	

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				PMID: 18722200 Review. 10. The Effectiveness of Non-Pharmaceutical Interventions Upon Pregnancy-Related Low Back Pain: A Systematic Review and Meta-Analysis. Koukoulithras I Sr, Stamouli A, Kolokotsios S, Plexousakis M Sr, Mavrogiannopoulou C. Cureus. 2021 Jan 30;13(1):e13011. doi: 10.7759/cureus.13011. PMID: 33728108 **Free PMC article.**	
Society for osteopathic healthcare	Evidence review U	General	General	**Additional search criteria** **Comment 7** A pubmed search including the terms osteopathy and pregnancy revealed 49807 studies. Adding the term OMT - which is an often applied key word and stands for Osteopathic Manipulative Therapy / Treatment reduced this list to 60 results. 4 of these were systematic reviews relating to pregnancy low back pain and or pelvic girdle pain, and manual therapy. 2 of these were included in the above list. The remaining two are available as full text articles and so should have been included in your literature review. Again, **we feel this is a significant oversight, and the papers in question reveal possibly relevant and likely provisional important data on the use of manual therapy (specifically**	Thank you for this comment and the list of references you have provided. As mentioned in the previous comment, the literature search focused on the population and condition thereby identifying any relevant intervention used for pelvic girdle pain. The references you have provided have been checked against criteria set in the review protocol. Please see the previous comment for the reason for exclusion for 2 of the references that you provided in the previous comment (Hall 2016 and Liddle 2015). For the other references, the reasons for exclusion are as follows: Hensel 2015 - the population for this study is not specific to pelvic girdle pain as specified in the protocol so cannot be included. Licciardone 2010 - the population for this study

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				osteopathic care) in relation to the management of pregnancy related MSK pain. We feel these papers should be reviewed, to evaluate if they inform the guidelines or not. The papers are: Pregnancy Research on Osteopathic Manipulation Optimizing Treatment Effects: The PROMOTE Study A Randomized Controlled Trial Kendi L. HENSEL, Steve BUCHANAN, Sarah K. BROWN, Mayra RODRIGUEZ, des Anges CRUSER Am J Obstet Gynecol. Author manuscript; available in PMC 2016 Jan 1. Published in final edited form as: Am J Obstet Gynecol. 2015 Jan; 212(1): 108.e1–108.e9. Published online 2014 Jul 25. doi: 10.1016/j.ajog.2014.07.043 PMCID: PMC4275366 **Abstract** **Objective** To evaluate the efficacy of Osteopathic Manipulative Treatment (OMT) to reduce low back pain and improve functioning during the third trimester in pregnancy and improve selected outcomes of labor and delivery. **Study Design** PROMOTE was a randomized, placebo-controlled trial of 400 women in their third trimester. Women were randomized to usual care only (UCO), usual care plus OMT (OMT), or usual care plus placebo ultrasound treatment (PUT). The study included seven treatments over nine weeks. The OMT protocol included specific	is not specific to pelvic girdle pain so cannot be included.

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				techniques administered by board-certified OMT specialists. Outcomes were assessed using self-report measures for pain and back-related functioning, and medical records for delivery outcomes. **Results** There were 136 women in the OMT group, 131 in PUT, and 133 in UCO. Characteristics at baseline were similar across groups. Findings indicate significant treatment effects for pain and back related functioning (*P*<.001 for both), with outcomes for the OMT group similar to that of the PUT, but both groups were significantly improved compared to UCO. For secondary outcome of meconium- stained amniotic fluid there were no differences between the groups. **Conclusion** OMT was effective for mitigating pain and functional deterioration compared to the UCO group; however OMT did not differ significantly from PUT. This may be attributed to PUT being a more active treatment than intended. There was no higher likelihood of conversion to high risk status based on treatment group. Therefore, OMT is a safe, effective adjunctive modality to improve pain and functioning during their third trimester. Osteopathic Manipulative Treatment of Back Pain and Related Symptoms during Pregnancy: A Randomized Controlled Trial John C. LICCIARDONE, Steve BUCHANAN, Kendi L. HENSEL, Hollis H. KING, Kimberly G. FULDA, Scott T. STOLL	

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				Am J Obstet Gynecol. Author manuscript; available in PMC 2011 Jan 1. Published in final edited form as: Am J Obstet Gynecol. 2010 Jan; 202(1): 43.e1–43.e8. Published online 2009 Sep 20. doi: 10.1016/j.ajog.2009.07.057 PMCID: PMC2811218 **Abstract** **Objective:** To study osteopathic manipulative treatment (OMT) of back pain and related symptoms during the third trimester of pregnancy. **Study design:** A randomized, placebo-controlled trial was conducted to compare usual obstetrical care (UOBC) and OMT (UOBC+OMT), UOBC and sham ultrasound treatment (UOBC+SUT), and UOBC only. Outcomes included average pain levels and the Roland Morris-Disability Questionnaire (RMDQ) to assess back-specific functioning. **Results:** Intention-to-treat analyses included 144 subjects. The RMDQ scores worsened during pregnancy; however, back-specific functioning deteriorated significantly less in the UOBC+OMT group (effect size, 0.72; 95% CI, 0.31-1.14; P=.001 vs. UOBC only; and effect size, 0.35; 95% CI, −0.06-0.76; P=.09 vs. UOBC+SUT). During pregnancy, back pain decreased in the UOBC+OMT group, remained unchanged in the UOBC+SUT group, and increased in the UOBC only group, although no between-group difference achieved statistical significance.	

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				Conclusion: Osteopathic manipulative treatment slows or halts the deterioration of back-specific functioning during the third trimester of pregnancy. The 2 overlap papers: Interventions for preventing and treating low-back and pelvic pain during pregnancy Sarah D Liddle, Victoria Pennick, Cochrane Pregnancy and Childbirth Group Cochrane Database Syst Rev. 2015 Sep; 2015(9): CD001139. Published online 2015 Sep 30. doi: 10.1002/14651858.CD001139.pub4 PMCID: PMC7053516 The effectiveness of complementary manual therapies for pregnancy-related back and pelvic pain: A systematic review with meta-analysis Helen Hall, Holger Cramer, Tobias Sundberg, Lesley Ward, Jon Adams, Craig Moore, David Sibbritt, Romy Lauche Medicine (Baltimore) 2016 Sep; 95(38): e4723. Published online 2016 Sep 23. doi: 10.1097/MD.0000000000004723 PMCID: PMC5044890	
Society for osteopathic	Evidence review U	General	General	**Comment 8** Whilst both of these papers (ABOVE) cannot point to strong evidence in support of manual therapy for pelvic girdle pain, **they do highlight other**	Thank you for your comment. We have responded to the issues you raise in the relevant comments below.

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healthcare				**aspects of interest which we feel should have been commented on in the NICE guidelines. We discuss these below.**	
Society for osteopathic healthcare	General	General	General	**Summary.** The International Society for Osteopathic Healthcare is established to provide information regarding osteopathic practice, for its members, practising osteopaths, the general public and other interested stakeholders. The ISOHC hosts a clinical special interest group for Women's Health, Obstetrics, Mother and Baby Support services given by osteopaths and practitioners utilising osteopathic philosophies in practise. The ISOHC has considered the draft NICE guidelines for the Antenatal Care and found them lacking in substance and relevance regarding manual therapy services in general and services provided by Osteopaths in particular. The guidelines consider only pelvic girdle pain as something that manual therapy in general may be recommended for, and does not include other presentations that affect pregnancy women, and may be amenable to manual therapy. We have strong concerns that the literature search strategies utilised has compromised the data retrieval which has led to the omission of important and relevant information regarding the use of manual therapy and the therapeutic role of osteopaths in health service provision for pregnant women. We fear that this may therefore weaken the guidelines and lead to a reduced quality of service for women in the perinatal period. We have strong concerns that this will adversely impact on the care currently experienced by women in the perinatal period, and the care services provided to pregnant women.	Thank you for this comment. The literature search focused on the population and condition (pregnancy and pelvic girdle pain), as our scope was to address interventions relevant for the management of pelvic girdle pain. Therefore it did not exclude any type of intervention or staff providing those interventions. Recommendations relevant to physiotherapy have been made based on the available evidence specific to physiotherapy in relation to pelvic girdle pain. Recommendations for osteopathic service provision for pelvic girdle pain were not made as there was no evidence to support such a recommendation. Regarding osteopathic services in general, other than for pelvic girdle pain, this is outside the scope of the guideline.

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				In the UK the osteopathic profession has gained Allied Health Profession Status[3] and can provide an overlap of a range of services with the physiotherapy profession, as well as providing its own care modalities. Hence references to interventions such as exercise and self-care advice, currently discussed under the remit of physiotherapy service provision should also include a recommendation to utilise osteopathic service provision. These elements of care provision are given by both professions and use the same science / evidence base and so recommendations should be for all the manual therapy allied health professionals' services, of **both** professions, to improve the access to healthcare for pregnant women, and to women in the perinatal period. Osteopaths have the competence and the scope of practice to provide health services in this regard, as well as for (but not limited to) the application of manual therapy and osteopathic techniques in the management of pain related conditions. The osteopathic profession (with over 5000 currently registered with the General Osteopathic Council (GOsC) sees many hundreds of pregnant patients on a weekly basis, and this represents an important part of the overall health service delivery for the antenatal and perinatal period. As part of the AHP team, osteopaths have been joining with the other members of the 14 professions, to support care delivery and care options	

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				for patients. There have been various strategy documents[4] and calls to action[5] regarding AHP service provision which include the need to: "*Support integration, addressing historical service boundaries to reduce duplication and fragmentation*" As osteopaths, as frontline, first contact practitioners, osteopaths are an important part of the health service team, enabling patient assessment, referral and direct care when appropriate, and are working hard considering how best to support the NHS and care services[6], in general and in this period of COVID care.[7] It is vitally important that osteopaths, as key AHP workers, can support the NHS, and be used to alleviate pressure on critical care services in times of crisis, and we do not wish the lack of inclusion in any care guidelines to hinder this cooperative dynamic. It is clear that Osteopaths can provide an independent but linked first contact practitioner role as antenatal care service providers, focusing mainly on MSK health issues, and the profession should be used as such. The NICE guidelines are a key element in care commissioning in NHS services, and if they do not reflect provision by all AHP's we consider this a significant barrier to information about service possibilities, hinders patient choice and may impact negatively on care pathways for pregnant women, and women in the antenatal and perinatal period. The role of osteopaths includes manual therapy, but also includes key components of care that	

[5] AHPs into Action Using Allied Health Professionals to transform health, care and wellbeing. ahp-framework-v1-9.pdf
[6] Osteopathy as an Allied Health Profession (AHP): Lessons from MDT work in the UK NHS Link
[7] Parliamentary Committees. Written responses. From the General Osteopathic Council. https://committees.parliament.uk/writtenevidence/4510/

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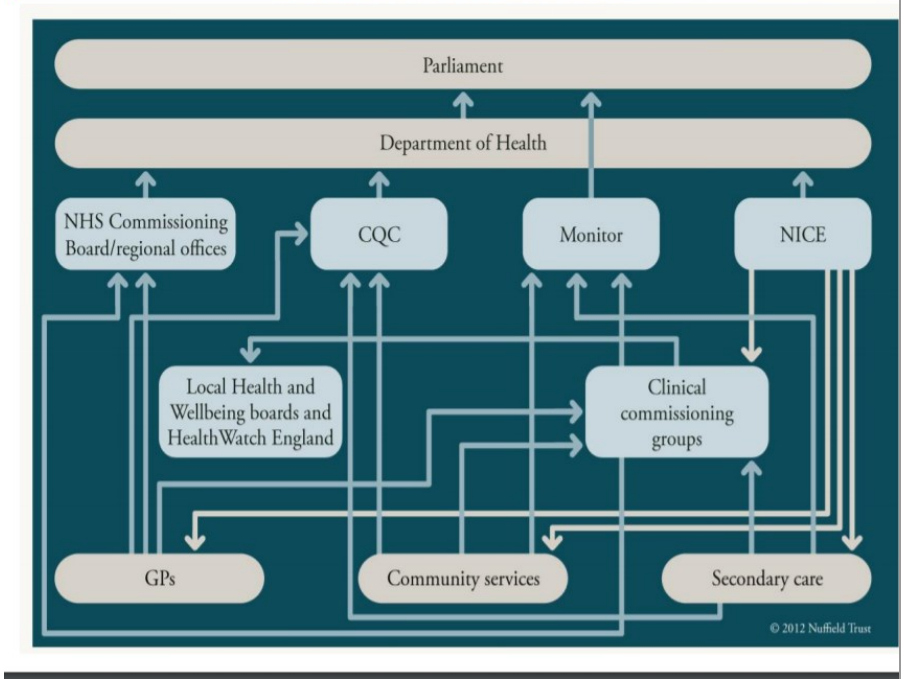
				AHP's should address such as self-care advice, education, referral services, and inter-professional liaison. See figure 1.  *Figure 1 From footnote 4*	

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				Recommendations for the antenatal period must also reflect the lived experiences of women, and their care choices and in omitting refence to the care provision by the osteopathic profession we believe this significantly impacts on women's health choices. We feel there is a range of evidence in support of the osteopathic role in antenatal care, and as such this should be reflected in the NICE Antenatal Guidelines. In addition, we highlight that many patients seek private rather than NHS services, and the guidelines should reflect this component of care provision – such that osteopathic and physiotherapy services provision across all modes of delivery should be a part of the guidelines. The guidelines should not relate solely to service provision given within the NHS only. **The communities (of patients and healthcare professionals) that the National Institute for Health and Care Excellence speaks to and for, should be inclusive and representative of all statutory regulated health professions in the UK, and all their patients and clients.** We submit a range of comments in this report, and hope that these will be taken into consideration.	
Society for osteopathic healthcare	General	General	General	**FACTORS IN ADDITION TO PELVIC GIRDLE PAIN** Wider benefits of manual therapy given to women during pregnancy and in the antepartum period may be present, whether given by osteopaths or other AHPs such as physiotherapists, beyond specific pelvic girdle pain.	Thank you for your comment. Additional musculoskeletal factors were not prioritised in the scope of this guideline update and therefore have not been addressed.

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				Additional musculoskeletal factors **Comment 10** We are concerned that pelvic girdle pain is the only musculoskeletal presentation included in the antenatal services. This, despite low back pain and back pain being included in the literature searches as terms for the various database searches in Appendix B. Pelvic girdle pain is not the only MSK complaint that causes significant distress to and reduction of quality of life in pregnant women. Low back pain[8] is a significant presentation for which many pregnant women seek help from osteopaths[9] in the antenatal period. **We feel its omission in the NICE antenatal guidelines is a very significant oversight, which should be addressed.**	
Society for osteopathic healthcare	General	General	General	**Non musculoskeletal system outcomes** **Comment 11** There may be additional benefits that manual therapy in the antenatal period, may provide for pregnant women during the pregnancy and the peripartum period. Non-musculoskeletal outcomes may be influenced by manual therapy – in other words some obstetrics outcomes may be affected by manual therapy intervention, and this is a potential significant contribution to maternal and obstetric services that should not be	Thank you for this comment. Non-musculoskeletal systems, and manual therapy applied to the pelvic floor were not areas prioritised in the scope of this guideline update. Thank you for providing the reference to Smith 2018. This systematic review does not meet our population of inclusion for the guideline as it is focused on interventions carried out to women during labour. NICE has separate guidance which

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				overlooked and warrants urgent research to potentially reduce maternal and infant morbidity. Whilst the evidence for this is currently insufficient to impact on obstetric care guidelines, **we strongly recommend that interprofessional research be undertaken in this regard.** Some of the reported obstetric and non-musculoskeletal outcomes that have been linked to the application of manual therapy are listed in figure 2.[10] The evidence for such outcomes is insufficient to form any strong view or recommendation, but, if supported by rigorous future research this would be a very beneficial adjunct to standard obstetric care. Additionally, manual therapy applied to the pelvic floor may be of benefit in reducing intrapartum tissue damage and reduce long term morbidity for women post partum.[11] Skilled practitioners such as women's health trained osteopaths and women's health trained physiotherapists can provide such services and health advice, and thus would have a role to play in a vital health service to improve the care for women in the peripartum period, Accordingly we recommend that **the range of presentations that NICE guidelines consider, and that could be provided by manual therapy AHPS such as physiotherapists and osteopaths, be increased.** There are also reports that manual therapy may be of benefit during labour and delivery for pain relief[12] and we feel that **the scope of future NICE guideline reviews should consider the intra-partum period as well as the antepartum period.**	considers interventions during the intrapartum period. Please see NICE guidance on 'Intrapartum care for healthy women and babies'.

[12] Smith CA, Levett KM, Collins CT, Dahlen HG, Ee CC, Suganuma M. Massage, reflexology and other manual methods for pain management in labour. Cochrane Database Syst Rev. 2018 Mar 28;3(3):CD009290. doi: 10.1002/14651858.CD009290.pub3. PMID: 29589380; PMCID: PMC6494169.

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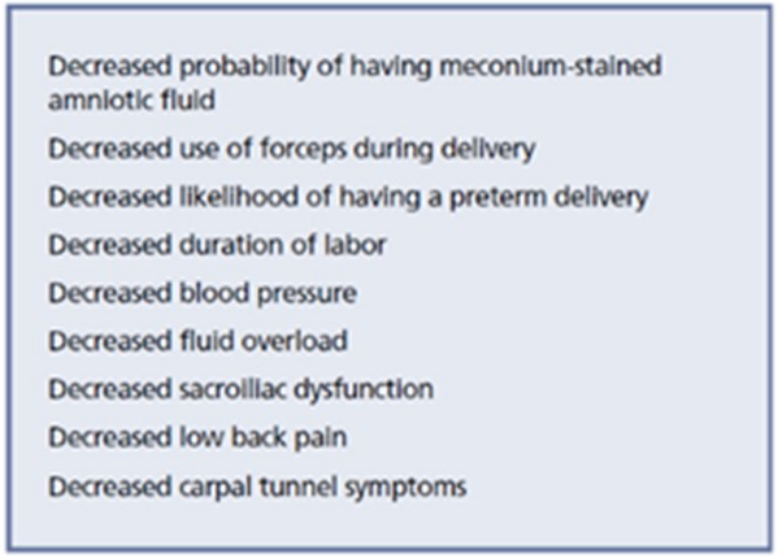
				Figure 2  Figure. *Benefits of osteopathic manipulative treatment in pregnant women.*[11,12,14,15,18,19,24-26] JAOA • Vol 112 • No 6 • June 2012 • **345**	

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Society for osteopathic healthcare	General	General	General	**ADVERSE EVENT REPORTING** **Comment 13** Preliminary observations of the data revealed in this report shows that although adverse event reporting is low, that the nature of adverse events reported IS low or no risk[13], and that therefore manual therapy and osteopathic are appear safe for pregnant women. We believe that given that many pregnant patients are seeing osteopathic and manual therapy providers, it is important information for healthcare professionals and the public alike to be aware of. **We consider that the NICE guidelines should include sections on evidence relating to the safety of interventions, as well as effectiveness.**	Thank you for your comment and reference to Franke 2017. Osteopathic services and manual therapy specific for pelvic girdle pain, were considered in this update of the antenatal care guideline. Osteopathy and manual therapy for other conditions were not prioritised for this update of the antenatal care guideline and are outside of the scope, therefore we have not included any of the included studies from the Franke 2017 systematic review as they do not meet our criteria set out in the protocol. We have considered adverse events when looking at interventions specific to pelvic girdle pain, which can be found in the protocol in Appendix A of evidence report U.
Society for osteopathic healthcare	Guideline	General	General	**On communication with women, and on information about antenatal services.** Osteopaths do not perform the midwifery . nursing and / or obstetrician role of antenatal screening or specific health guidance and antenatal monitoring, for example. However, osteopaths through their engagement with many pregnant women and their partners, are aware of many fears, concerns, confusions and lack of awareness that women and their partners may have, and that this can impact on their experiences and choices during their antenatal and	Thank you for the comment. Osteopathic care was not a topic that was included in the scope of this guideline and evidence on it was not

[13] Franke H, Franke JD, Belz S, Fryer G. Osteopathic manipulative treatment for low back and pelvic girdle pain during and after pregnancy: A systematic review and meta-analysis. J Bodyw Mov Ther. 2017 Oct;21(4):752-762. doi: 10.1016/j.jbmt.2017.05.014. Epub 2017 May 31. PMID: 29037623.

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				perinatal period, and which may impact on bonding are care giving skills within the new family unit. As such osteopaths are important contributors to conversations that enable women and their partners to understand the need for communication with their main antenatal care team, and osteopaths, as well as physiotherapists, are well placed to help women and their partners find appropriate care and support. The following papers should inform stakeholders as to the patient's lived experiences of consulting with osteopaths during the antenatal period and highlight the fact that the profile of the patients seeking osteopathic care, and the cost-benefit-risk profiles in this regard are not fully researched. As many patients are and will continue to seek osteopathic care during pregnancy, it is vital that more data is gathered about this service provision. In this regard much future research on collaborative team working between AHP's and other antenatal care / service providers would be highly valuable, and so **we recommend inter-disciplinary research be undertaken as a priority.** Where it is clear that patients are seeking osteopathic care, it would also be appropriate for the NICE guidelines to **reflect and recommend that more education for medical and healthcare professionals be provided,** to reduce stereotypes and outdated knowledge of training and education, skills and competence profiles of osteopaths, to clarify and remove barriers to health care that could significantly benefit women in the antenatal period. See table 1 on next page.	reviewed so the committee has not commented on it.

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<table>
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<tr><td></td><td></td><td></td><td></td><td>

Table 1

<table>
<tr><th>STUDY</th><th>POPULATION</th><th>INTERVENTION</th><th>COMPARISON / DETAILS</th></tr>
<tr><td>Experiences of pregnant women receiving osteopathic care</td><td>Pregnant patients who were undergoing osteopathic care in northern NSW and south-east Queensland, Australia. Data were analysed thematically.</td><td>Osteopathic care</td><td>This phenomenological study used semi-structured interview with pregnant wom to ascertain their experiences of receiving osteopath care</td></tr>
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								• Conclusions: Pregnant women receiving osteopathic care reported experiencing physical and mental health benefits both during pregnancy and in the post-natal period.
				Prevalence and characteristics of women who consult with osteopathic practitioners during pregnancy; a report from the Australian Longitudinal Study on Women's Health (ALSWH)	The study sample was obtained via the Australian Longitudinal Study on Women's Health (ALSWH). The women answered questions about consultations with osteopathic practitioners, pregnancy-related health	Osteopathic care	A total response rate of 79.2% (1835) was obtained. Of these, 104 women (6.1%) consulted with an osteopath during pregnancy for a pregnancy-related health condition. Women were more likely to consult an osteopath if they suffered from back pain, sadness, weight management issues, or had a history of retained placenta.	Women are visiting osteopaths for help with common pregnancy health complaints, highlighting the need for research to evaluate the safety, clinical and cost effectiveness of osteopathy in pregnancy.

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	concerns and attitudes to CM use.			

Sheraton A, Streckfuss J, Grace S. Experiences of pregnant women receiving osteopathic care. J Bodyw Mov Ther. 2018 Apr;22(2):321-327. doi: 10.1016/j.jbmt.2017.09.007. Epub 2017 Sep 11. PMID: 29861226.

Frawley J, Sundberg T, Steel A, Sibbritt D, Broom A, Adams J. Prevalence and characteristics of women who consult with osteopathic practitioners during pregnancy; a report from the Australian Longitudinal Study on Women's Health (ALSWH). J Bodyw Mov Ther. 2016 Jan;20(1):168-172. doi: 10.1016/j.jbmt.2015.03.004. Epub 2015 Mar 21. PMID: 26891652.

Table in text only form:

STUDY POPULATION INTERVENTION COMPARISON / DETAILS OUTCOMES

Experiences of pregnant women receiving osteopathic care Pregnant patients who were undergoing osteopathic care in northern NSW and south-east Queensland, Australia. Data were analysed thematically.

Osteopathic care This phenomenological study used semi-structured interviews with pregnant women to ascertain their experiences of receiving osteopathic care • Osteopathic care provided symptom relief, particularly for low back and pelvic pain.

• Participants wanted a natural childbirth with minimal medical intervention if possible.

• Osteopathic care was perceived as helping prepare women's bodies for birth and in so doing helped alleviate anxieties associated with childbirth and with entering the mainstream medical system.

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				• Conclusions: Pregnant women receiving osteopathic care reported experiencing physical and mental health benefits both during pregnancy and in the post-natal period. Prevalence and characteristics of women who consult with osteopathic practitioners during pregnancy; a report from the Australian Longitudinal Study on Women's Health (ALSWH) The study sample was obtained via the Australian Longitudinal Study on Women's Health (ALSWH). The women answered questions about consultations with osteopathic practitioners, pregnancy-related health concerns and attitudes to CM use. Osteopathic care A total response rate of 79.2% (1835) was obtained. Of these, 104 women (6.1%) consulted with an osteopath during pregnancy for a pregnancy-related health condition. Women were more likely to consult an osteopath if they suffered from back pain, sadness, weight management issues, or had a history of retained placenta. Women are visiting osteopaths for help with common pregnancy health complaints, highlighting the need for research to evaluate the safety, clinical and cost effectiveness of osteopathy in pregnancy. Sheraton A, Streckfuss J, Grace S. Experiences of pregnant women receiving osteopathic care. J Bodyw Mov Ther. 2018 Apr;22(2):321-327. doi: 10.1016/j.jbmt.2017.09.007. Epub 2017 Sep 11. PMID: 29861226. Frawley J, Sundberg T, Steel A, Sibbritt D, Broom A, Adams J. Prevalence and characteristics of women who consult with osteopathic practitioners during pregnancy; a report from the Australian Longitudinal Study on Women's Health (ALSWH). J Bodyw Mov Ther. 2016 Jan;20(1):168-172. doi: 10.1016/j.jbmt.2015.03.004. Epub 2015 Mar 21. PMID: 26891652.	

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Society for osteopathic healthcare	Guideline	General	Appendix J	**ECONOMIC ANALYSIS – APPENDIX J** **Comment 14** The cost benefit analysis conducted thoroughly on the paper discussing the use of lumbopelvic support belts in pregnancy is useful, but of course represents a cost analysis for NHS budgeting purposes. Whilst this is clearly necessary, we would advocate that cost benefit analysis for pregnant women is also considered – as in loss of days off work, having to take maternity leave early because of pain and functional disability issues, and the subsequent cost both economically and emotionally to the new family unit, and for any social support claims that might need to be made by the patient, as well as any long term health and well being and emotional consequences that might impact on infant care, and on the quality of life and functioning of the woman post-partum, which may place additional costs onto general health services. There is evidence that such a cost benefit of exercise therapy for pain related sick leave[14] and that whilst there was low quality evidence for manual therapy including osteopathy for improvement in functional disability reported in the same paper, this should be a strong priority for a research call within the NICE guidelines. **We would recommend that inter-disciplinary and economic cost analysis for the patient is included within research strategies, and related data to be included in the NICE guidelines.**	Thank you for this comment. For NICE guidelines economic evaluations of interventions funded by the NHS and personal social services (PSS) should only include costs incurred by the NHS and PSS. (https://www.nice.org.uk/process/pmg20). A wider perspective around costs, including productivity and costs to other government agencies were therefore not included in the economic evaluation for this topic.

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Society for osteopathic healthcare	Guideline	054	025	The guidelines should not relate only to that service provision given within the NHS only, and should not exclude an existing component of the AHP service provision. The Communities that the National Institute for Health and Care Excellence should be inclusive and representative of all statutory regulated health professions in the UK, and all their patients and clients. Osteopaths as AHP's should be included as a recommended service – osteopaths are employed within the NHS as AHPs and work across a range of positions, including MKS services, as well as in GP practices for example, as well as in private practice. Osteopaths' scope of practice includes the provision of antenatal care services. Osteopathic service providers can (and do) provide telehealth and not-in-person services, as well as face to face consultations.	Thank you for this comment. The review protocol did not exclude osteopaths, and therefore they were not excluded from the search strategy for the review for pelvic girdle pain. The committee make recommendations based on the available evidence. Recommendations specific to osteopathic services for pelvic girdle pain were not made as there was no evidence to support them.
Society for osteopathic healthcare	Guideline	054	029	Osteopaths are trained in and are competent to give advice and education on anatomy and posture, in general and in pregnancy. We would like to see the guidelines reflect that osteopaths can provide this component in their service provision. We would also like to highlight that many osteopaths routinely discuss the use of support belts in their management of pregnant patients, and the guidelines should reflect that this is a service that osteopaths can offer.	Thank you for this comment. The review protocol did not exclude osteopaths, and therefore they were not excluded from the search strategy for the review for pelvic girdle pain. The committee make recommendations based on the available evidence. Recommendations specific to osteopathic services for pelvic girdle pain were not made as there was no evidence to support them.
Society for osteopathic healthcare	Guideline	055	010	Osteopaths are trained in and are competent to discuss and deliver advice on lifestyle and health changes. We would like to see the guidelines reflect that osteopaths can provide this component in their service provision.	Thank you for this comment. The review protocol did not exclude osteopaths, and therefore they were not excluded from the search strategy for the review for pelvic girdle pain. The committee make recommendations based on the available evidence.

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					Recommendations specific to osteopathic services for pelvic girdle pain were not made as there was no evidence to support them.
The Down's Syndrome Association	Guideline	001	General	We fully support the recommendation that "*People have the right to be involved in discussions and make informed decisions about their care*".	Thank you.
The Down's Syndrome Association	Guideline	001	General	We agree that *"Healthcare professionals should ensure that women have the information they need to make decisions and to give consent"*. Information provided to pregnant women should be regularly reviewed to ensure that it is up to date and accurate and the language used is acceptable. The Down's Syndrome Association has been pleased to be involved in the Fetal Anomaly Screening Programme Education Sub Group, which has had oversight of reviewing information resources provided to women during the antenatal period.	Thank you for this comment.
The Down's Syndrome Association	Guideline	005	*009*	*"At the point of referral, provide early pregnancy information and an easy-to-complete referral form. Ensure that the materials are available in different languages or formats such as digital, printed, braille or Easy Read*". We agree, but would state that are aware that the move to online formats for information, as a default, poses certain challenges and it is essential that attention is paid to the issues of digital exclusion, understanding that not	Thank you for this comment. The committee agrees that information should be provided in various formats so that it meets the needs and preferences of individual women (and their partners). The recommendations specifically state that information provided orally should be "supplemented by written information in a

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				all women will be comfortable or able to access information that is not printed.	suitable format, for example, digital, printed, braille or Easy Read".
The Down's Syndrome Association	Guideline	006	017	"*Offer additional or longer antenatal appointments if needed, depending on the woman's medical, social and emotional needs*". We are concerned that some women experience antenatal appointments that seem rushed, an initial booking appointment (where antenatal screening for chromosomal conditions such as Down's syndrome would be introduced) could take a considerable amount of a midwife's time to cover properly, especially if a women or couple have additional questions they want to ask. These pregnancies would not necessarily involve women with greater medical, social or emotional needs.	Thank you for this comment. The committee agreed not to be prescriptive about the length of the appointments but wanted to emphasise that enough time is provided for questions and discussions (see recommendations under 'Communication').
The Down's Syndrome Association	Guideline	006	023	*"Ensure that reliable interpreting services are available if needed"*. We agree and would stipulate that these should, wherever possible, be professional interpreters. Too often, reliance is placed upon family members , who may, or may not, be accurate in their use of terminology or objective in their explanation of more complex issues.	Thank you for this comment. We have revised the wording so that it is clear that the interpreter should be independent of the woman.
The Down's Syndrome Association	Guideline	007	001	"*Those responsible for planning and delivering antenatal services should aim to provide continuity of carer"*. We strongly agree with this statement, as relationships need to build between women and the health professionals supporting them. This should be coupled with a robust system for women to raise a complaint about an individual health professional, should there	Thank you for this comment. We hope that the guideline will enable women to receive the best possible care during their pregnancy.

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				be concerns about the way in which her care is being managed. If women consistently see a professional who is unable to support her in the way in which she needs, continuity of care actually works against a good quality experience.	
The Down's Syndrome Association	Guideline	011	001	"*At the first antenatal (booking) appointment, offer the following screening programmes: NHS infectious diseases in pregnancy screening programme (HIV, syphilis and hepatitis B), NHS sickle cell and thalassaemia screening programme, NHS fetal anomaly screening programme"*. It is essential that this is not seen as box-ticking exercise. Too often screening is seen as a routine aspect of antenatal care, rather than an elective process, where women should be given up to date and accurate information in order for them to make an informed decision about what, if any, prenatal tests they wish to have. The giving of information needs to be supported by a discussion with a well-trained health professional, who is objective, compassionate and non-directive. The Down's Syndrome Association's RCM accredited Tell it Right training programme for midwives is focused on developing these skills within antenatal care settings.	Thank you for this comment. The committee revised the recommendations so that it is clear that information about the screening programmes/tests should be provided and discussed. Further guidance on how to communicate and have discussions is provided in the 'Communication – key principles' section.
The Down's Syndrome	Guideline	011	007	*"Offer pregnant women an ultrasound scan to take place between 11+2 weeks and 14+1 weeks to: determine gestational age, detect multiple pregnancy, screen for Down's syndrome, Edward's syndrome and Patau's syndrome (see the NHS fetal anomaly screening programme)"*. This should be a process of	Thank you for this comment. The committee agreed and has revised the recommendations so that it is clear that information about screening programmes is provided and discussed. The committee made a general recommendation that

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Association				checking understanding, giving opportunity for questions and finally gaining informed consent.	for any intervention or procedure that is offered, its benefits, harms and implications should be discussed and the woman should be made aware that she can decline.
The Down's Syndrome Association	Guideline	016	011	*"When giving women (and their partners) information about antenatal care, use clear language, and tailor the timing, content and delivery of information to the needs and preferences of the woman and her stage of pregnancy. Information should support shared decision making between the woman and her healthcare team"*. We fully endorse this statement. In relation to antenatal screening for fetal anomaly, this should come from a position that screening is offered and not specifically recommended, it is down to the informed decision making of the woman.	Thank you for this comment.
The Down's Syndrome Association	Guideline	017	008	"*Explore the knowledge and understanding that the woman (and her partner) has about each topic to individualise the discussion"*. Agreed and additionally there needs to be an understanding that, sometimes, couples may have different information needs and be at different stages of their understanding, requiring a differentiated and individualised approach.	Thank you for this comment, this is implicit in the recommendation.
The Down's Syndrome Association	Guideline	018	004	"*At the first antenatal (booking) appointment, discuss and give information on:…… how to get in touch with local or national peer support services"*. We fully support this aim. The Down's Syndrome Association is able to provide additional information for pregnant women and their partners and offer	Thank you for this comment.

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				time and space to discuss concerns or answer questions. We welcome contact from women at all stages of their pregnancy.	
The Down's Syndrome Association	Guideline	018	026	"*At the first antenatal (booking) appointment, discuss and give information about…*" Additionally, we would include here information about fetal anomaly screening, as women need to begin thinking about this at the earliest opportunity and may want to go away and do additional reading or consult with other specialist organisations before meeting their midwife and asking questions at their booking appointment.	Thank you for this comment. The committee has added screening programmes to the list of topics to discuss.
The Down's Syndrome Association	Guideline	019	004	"*Throughout the pregnancy, discuss and give information on: emotional and relationship changes during the pregnancy, how the woman and her partner can support each other, resources and support for expectant and new parents, how the parents can bond with their new-born baby and the importance of emotional attachment (also see the section on xxx in the NICE guideline on postnatal care [LINK TO GUIDELINE UPDATE TO BE ADDED]), the results of any blood or screening tests from previous appointments.*" We would include here referral to other organisations that can provide a sources of impartial, confidential, information and support e.g. The Down's Syndrome Association, SOFT, ARC (especially when higher chance results are communicated).	Thank you for this comment. A previous recommendation about information provision and discussion at the booking appointment includes discussion around resources and support for expectant and new parents and how to get in touch with local or national peer support services. The committee has now revised the recommendation to say "and later if appropriate" so that these are covered also later on in pregnancy as needed.

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The Down's Syndrome Association	Guideline	021	015	"*Discuss the potential benefits of peer support with pregnant women (and their partners), and explain how it may: provide practical support, help to build confidence, reduce feelings of isolation and 1.3.18 Give pregnant women (and their partners) information about how to access local and national peer support services"*. For women who have a higher chance result from a predictive screening test for Down's syndrome (or a confirmed prenatal diagnosis from a diagnostic test) be aware of the tailored support available for The Down's Syndrome Association and specialist resources e.g. the DSA "*Looking Forward to Your Baby*" booklet and regular online webinars for pregnant women facilitated by the Association.	Thank you for this comment. The additional care for women who have a higher chance result from a predictive screening is not covered by this guideline which is routine antenatal care, however, we recognise the value of different resources, information and support.
The Royal College of Midwives	Guideline	018	011-012	This is too detailed for a national guideline- it is assuming there will be different numbers to call. Some midwifery teams will divert to the unit when out-of-ours and in continuity teams there is one point of access 24/7. This could just say how to contact the midwifery team in out-of hours	Thank you for this comment which the committee discussed. The point of the recommendation is to avoid a situation where for example, a woman leaves a voice mail to her midwife that she is bleeding. The specific arrangements will vary locally but the committee agreed that it is important to make a distinction between urgent and non-urgent situations.
The Royal College of Midwives	Evidence Review M	General	General	There is also a published ECV cost-effectiveness study, which determined that it is only cost-effective if over 32% successful (21). Significant observational evidence indicates that success rates vary depending on the operator, exemplified by the 14% success rate reported by Wastlund (22) versus the 49% success rate reported by Melo (16) recently in the UK.	Thank you for this comment. Although there was no evidence identified for this topic in evidence review M, the committee discussed the variation in success rates of ECV can be attributable to the experience of the provider. Based on your and other stakeholder comments, the discussion

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				Women in our network also wanted guidelines to acknowledge the wide variation in success rates attributable to the experience of the provider and to recommend research in this area.	section of evidence review M has been amended to include this point. Thank you for providing references to Melo 2019 and Wastlund 2019. The study Melo 2019 was excluded at the title and abstract stage of the systematic review process because it uses a cohort study design, which falls into the exclusion criteria for evidence review M and therefore was not included. The study Wastlund 2019 has been included in review L 'Identification of breech presentation' in the health economic analysis.
The Royal College of Midwives	General	General	General	There seems to be a language issue throughout the guidance when it comes to referring women or taking measurements. All interventions, referral, examination and investigation should be offered with no assumptions that all women will accept all suggested procedures.	Thank you for this comment. The language has been revised throughout the guideline as suggested.
The Royal College of Midwives	General	General	Genral	Consider being less prescriptive on when topics should be discussed with women as each individual is different. Midwives are the primary providers of antenatal care and should be able to personalize care based on the woman's needs and wants. Midwives should be enabled to offer holistic care that takes into consideration the social component of pregnancy and tailor the conversation to enable mental and emotional safety for women. Focusing on a list of 'tasks' does remove time and space for midwives to hold what should be a safe space for women.	Thank you for this comment which the committee discussed. The committee carefully considered when different topics should be discussed, in order to balance the amount of information provided at different times and the relevance of different conversations in relation to the phase of pregnancy. However, the committee also agrees that the discussions should individualised and agreed to revise the wording of the recommendations to add more flexibility around the timing of the discussions.

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					Furthermore, the recommendations make it clear that the care overall is person-centred and many of the discussions will be led by the needs and preferences of the woman herself.
The Royal College of Midwives	General	General	General	There should be consistency in language and tone with the NICE shared decision-making guideline CG138.	Thank you for this comment. The language has been revised throughout the document as suggested.
The Royal College of Midwives	General	General	General	An opportunity exists at various stages along the antenatal care pathway for midwives to promote breast cancer awareness through self-examination. Currently there are no protocols for routine and specific questioning or discussion by midwives about promoting self-breast examination and discussing breast cancer prevention. Significant statistics demonstrate the impact of breast cancer in the UK; 10 000 women are diagnosed with breast cancer before age of 50, with 1:3000 women diagnosed with breast cancer in pregnancy Breast cancer statistics | Cancer Research UK. Midwifery Standards outline the public health interventions midwives are able to provide, to support women's health across the life-course: Domain 3 (3.2) 'understand epidemiological principles and critically appraise and interpret current evidence and data on public health strategies, health promotion, health protection, and safeguarding, and use	Thank you for this comment. This was not a topic that was included in the scope of this guideline and evidence on it was not reviewed so that committee has not commented on it.

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				this evidence to inform conversations with women, their partners, and families, as appropriate to their needs and preferences' Standards for midwives - The Nursing and Midwifery Council (nmc.org.uk) Unicef Baby Friendly Initiative standards already require midwives to discuss well documented evidence of the protection offered by breastfeeding in breast cancer prevention The Unicef UK Baby Friendly Initiative.	
The Royal College of Midwives	Guideline	012-013	006-022	Offer BP readings at every appointment and referrals where appropriate	Thank you for this comment. The committee agrees and the recommendations in this section reflect this.
The Royal College of Midwives	Guideline	020-021	009-009	Place of birth should be included in the offer of AN preparation. Healthy low risk multips should be offered 'homebirth workshops' or similar.	Thank you for this comment. The committee decided not to be prescriptive regarding the exact content of antenatal classes, however, discussions around place of birth will likely be included in antenatal classes around preparation for labour and birth. Specific recommendations around place of birth are covered by the NICE guideline on intrapartum care for healthy women and babies. The antenatal care guideline makes a cross-reference to this guideline in relation to discussions around birth preferences.

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The Royal College of Midwives	Guideline	005	004	The word 'starting' could be replaced by 'offering'	Thank you for this comment. This section is about starting antenatal care and we have kept the wording as it is. However, we have revised the language throughout the guideline to emphasise the choice that the women have on the care.
The Royal College of Midwives	Guideline	005	007	This should include midwives as it does include GPs, school nurses and community centres. Most women will self-refer to their maternity unit or local midwifery team, excluding midwives is peculiar.	Thank you for this comment. We have added 'midwife' to the list.
The Royal College of Midwives	Guideline	006	001	Assessment of referral forms is mostly carried out by midwives, please include midwives here.	Thank you for this comment, we have made the suggested change.
The Royal College of Midwives	Guideline	007	002	This is great to see and in line with the evidence. However, it should mention midwifery continuity of care, not just continuity.	Thank you for this comment. Continuity of carer models were not reviewed by this guideline committee so we have not commented on the details, however, we have defined the term 'continuity of carer' (there is a direct link to the definition in the recommendation) which states that this is based on the Better Births model of midwife continuity of carer.

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The Royal College of Midwives	Guideline	007	011	This refers to 'antenatal units' when most antenatal care will be delivered in the community, including women's homes. The term unit could be replaced with community hub as recommended in Better Births.	Thank you for this comment, we have revised the wording in this recommendation so that it does not mention antenatal units.
The Royal College of Midwives	Guideline	007	017	The assumption here is the woman has support, which may not be always the case. It could state 'her home situation and available support network'	Thank you for this comment. We have amended the wording as suggested.
The Royal College of Midwives	Guideline	009	002	Women from these backgrounds may need enhanced care pathways and/or support not necessarily closer monitoring is the evidence-based recommendation	Thank you for this comment. Evidence on this was not reviewed so the committee were not able to give detailed guidance on this, however, they agree that additional support may be needed and have added this to the recommendation.
The Royal College of Midwives	Guideline	009	020	The referral should be offered to women as the info on available local services for smoking cessation	Thank you for this comment, we have amended the wording as suggested.
The Royal College of Midwives	Guideline	010	014	'Reassess the pattern of care' does this refer to clinical assessment and care plan? It seems unclear.	Thank you for this comment. We have revised the wording to say "plan of care".

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The Royal College of Midwives	Guideline	010	020	Examinations and investigations should be offered, same with measuring height/weight and BMI	Thank you for this comment, the wording has been revised accordingly.
The Royal College of Midwives	Guideline	012	019	The test should be offered, the referral only takes place once the woman has agreed. This is important to state clearly. All interventions, referral, examination and investigation should be offered.	Thank you for this comment. The recommendation wording has been amended as suggested.
The Royal College of Midwives	Guideline	014	002	'Carry out' should again be replaced by offer assessment of 'fetal growth and wellbeing'	Thank you for this comment, we have made the suggested change.
The Royal College of Midwives	Guideline	014	016	Offer a scan not perform	Thank you for this comment, we have made the suggested change.
The Royal College of Midwives	Guideline	014	021	Fetal movement is something women may want to ask about before 24 weeks even if it applies after.	Thank you for this comment. Yes, this may be the case and the guideline states that any questions or concerns that the woman might have should be listened and responded to. However, In general the committee carefully considered the approximate timing for

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					information provision to be aligned with the relevant phase of the pregnancy, not least to avoid information overload in the beginning of the pregnancy.
The Royal College of Midwives	Guideline	015	011-020	The section on breech management should acknowledge the wide variation in practice and emphasis choice and informed decision making explicitly.	Thank you for this comment. The committee agreed to change the recommendation so that all the options and their benefits, risks and implications should be discussed. The committee also added a general recommendation that it should be ensured that when any investigation or procedure is offered, the risks, benefits and implications are discussed with the woman and she is aware that she has a right to decline.
The Royal College of Midwives	Guideline	018	009	Midwives will be involved in the care of all women, this should state which additional healthcare professional if any. The primary care providers of AN care are midwives	Thank you for this comment but we do not think the suggested change is necessary. The discussion about the midwives' role may also be relevant.
The Royal College of Midwives	Guideline	019	003-008	This is again quite prescriptive. There is no need to reiterate what midwives should discuss with women at each appointment, particularly not offering repeatedly induction of labour. The RCM guidelines states: Unless the clinical situation changes, midwives should not make frequent offers of this intervention. https://www.rcm.org.uk/media/3552/midwifery-care-for-induction-of-labour-a4-2019-16pp_2.pdf	Thank you for this comment. The committee has revised the recommendations so that they do not give the impression that the issues should be discussed at every appointment but rather when appropriate. The committee tried to find a balance between giving pointers to what should

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					be discussed and approximately at what stages of pregnancy so that information provision and discussions are meaningful and relevant.
The Royal College of Midwives	Guideline	019	020-022	Please refer to RCM guidelines on care in labour and amend language 'coping with labour or coping techniques' https://www.rcm.org.uk/media/2539/professionals-blue-top-guidance.pdf	Thank you for this comment, we have revised the wording as suggested.
The Royal College of Midwives	Guideline	021	020	Consider rewording from 'give' to 'offer'	Thank you for this comment, we have revised the wording as suggested.
The Royal College of Midwives	Guideline	023	001	Decision making should be supported not shared	Thank you for this comment. NICE supports shared decision making and more information about what that entails and what it means is covered on the NICE website: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making
The Royal College of Midwives	Guideline	030	005-019	This is great to see and in line with Better Births. However the overwhelming body of evidence refers to midwifery continuity model so this should be made clear that is referring to midwives and not just 'health professionals' https://www.cochrane.org/CD004667/PREG_midwife-led-	Thank you for this comment. While the overall definition is based on the Better Births and generally refers to midwifery care, this may be extended to cover other healthcare professionals as well.

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				continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early	
The Royal College of Midwives	Guideline	513	General	Consider replacing 'to start' with 'being offered'	Thank you for this comment. This section is about starting antenatal care and we have kept the wording as it is. However, we have revised the language throughout the guideline to emphasise the choice that the women have on the care.
The UK National Screening Committee (UK NSC)	Evidence review O	General	General	There is no comparison of US versus SFH done <7days from birth. This is an important comparison and is critical for deciding on policy. According to the evidence review protocol with SGA/LGA detection as targets, US appears more accurate than SFH across the board of comparisons. The committee use the lack of evidence for improved clinical outcomes as a reason for non-adoption of routine US. However, most of the cited evidence used US without a protocol of clinical management – when ultrasound is an investigation which cannot improve outcomes unless linked to a clinical management protocol. Having concluded that US is not suitable for improving clinical outcomes, why does the committee recommend an US when a low/high SFH. What is there evidence that this process improves clinical outcomes? If such evidence exists, then it would justify routine third trimester use of US.	Thank you for this comment. The committee sought to find the accuracy of SFH and US. In order to estimate the accuracy, both methods need to be compared against a reference standard and not to each other (comparing SFH and US head to head would not give information about their accuracy but rather how well they compare to each other). Overall the evidence identified in this review (Review O) suggested that neither US nor SFH were particularly accurate, with sensitivity being particularly poor. The committee discussed that US is more accurate than SFH but it is still not very accurate. The results of this review were interpreted alongside evidence review Q on routine third trimester ultrasound for fetal growth. That review broadly concluded that routinely ultrasound scanning all women in the third

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				This policy recommendation is not consistent with equivalent recommendations in Europe or North America.	trimester did not convey a clinically important benefit. Therefore, the committee could not justify recommending US over SFH, whilst also considering the big difference in resources/costs and practice change. The committee's conclusion was that routine US does not seem to be beneficial when compared to selective US and agreed that there was insufficient evidence to justify change in current practice of offering SFH and selective US.
The UK National Screening Committee (UK NSC)	Guideline	006	General	NICE has maintained the booking by 10 weeks and added a 2 week turn around for women booking 9+0 weeks- it would be useful if they could make a recommendation to maternity services about having processes to audit women who book late to better understand the factors which may cause this as they have recognised in the evidence review that this group of women are often vulnerable and where inequalities may exist.	Thank you for this comment. The committee have added a new recommendation to capture this important point.
The UK National Screening Committee (UK NSC)	Guideline	007	021	Consider virtual appts- need to be cautious that disadvantaged groups and not further disadvantage by blanket polices of virtual appointments	Thank you for this comment. The committee agrees and we have added a comment about this to the 'Why the committee made the recommendations section'.
The UK National	Guideline	008	004	Recommendation 1.2.1	Thank you for this comment and for the information. Antenatal and postnatal mental

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Screening Committee (UK NSC)				The UK NSC would like to inform the committee the screening for Screening for antenatal and postnatal mental health problems is part of the regular UK NSC evidence review update (https://legacyscreening.phe.org.uk/postnataldepression). The 2019 UK NSC evidence review found that there are a wide range of potential screening tests, symptoms of common mental health problems and interventions investigated that have led to a large volume of evidence for this topic. However, the studies are typically small and vary significantly in methodology, level of bias and consistency of results; therefore it is difficult to use such evidence to guide policy makers in their decision on national screening programmes. Therefore larger studies on test accuracy and treatment effectiveness would provide a better estimate than current evidence. Such evidence would need to use an agreed definition of common mental health problems and studies on treatment would also need to use agreed clinically meaningful outcomes. We would suggest the following edit (below in red) 1.2.1 At the first antenatal (booking) appointment, ask the woman about: o her medical history, obstetric history o current and recent medicines, including over-the-counter medicines and health supplements o allergies o her occupation, discussing any risks and concerns o her home situation and the support she has	health are covered by another NICE guideline (CG192) which recommends asking about mental health concerns at booking appointment. The committee also feels strongly that mental health during and after pregnancy is such an important area and a cause for adverse outcomes that it should be routinely discussed.

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				○ factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use; see also recommendation 1.3.7 If there are concerns discuss also: ○ family history previous or current mental health concerns, to identify possible depression and anxiety in line with the section on depression and anxiety disorders in the NICE guideline on antenatal and postnatal mental health ○ any past or present severe mental illness or psychiatric treatment in line with the section on severe mental illness in the NICE guideline on antenatal and postnatal mental health	
The UK National Screening Committee (UK NSC)	Guideline	009	028	Recommendation 1.2.7 The UK NSC would like to inform the committee the screening for Partner Violence is part of the regular UK NSC evidence review update (https://legacyscreening.phe.org.uk/partnerviolence). Although the 2019 evidence review did identify several screening tests used to evaluate the risk of partner violence, overall, none of the tests were accurate enough to be used in a screening programme, and the data was conflicting. Moreover, no tools were particularly designed for pregnant women. We therefore suggest that more research is needed to evaluate the accuracy and appropriateness of such tests especially in the pregnant population.	Thank you for this comment. The committee is aware that it is not recommended as a screening programme, however, their strong view is that because of the prevalence and harms of domestic abuse, this should be enquired from all pregnant women in a kind, sensitive manner and when they're alone so that appropriate safeguarding and support can be provided.

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The UK National Screening Committee (UK NSC)	Guideline	011	General	Can NICE add something about providers making sure women have access to the nationally developed and provided information for antenatal screening at the first booking appointment (or preferably earlier at first contact) either in digital format or hard copy dependent on the women's needs please. It would be better here alongside the offer of screening but if not then in the section on information on page 18.	Thank you for this comment. The committee revised the recommendations in both sections so that it is clear that information about the screening programmes/tests should be provided.
The UK National Screening Committee (UK NSC)	Guideline	011	001	Regarding the NHS screening programmes; The comment states women should be offered screening. For the Fetal anomaly and Haemaglobinopathies screening programmes women should be offered this screening however women should be offered and recommended the NHS infectious diseases screening programme. In the interests of consistency, can this be amended to state women should be offered and recommended NHS infectious diseases screening.	Thank you for this comment. 'Offer' in NICE guidelines means it is a strong recommendation, therefore, all screening programmes are recommended in line with the national screening programmes, however, the guidance also makes it clear that information about these should be provided and the woman has the right to decline any part of any of the screening programmes.
The UK National Screening Committee (UK NSC)	guideline	011	007	Offer pregnant women an ultrasound scan to take place between 8 11+2 weeks and 14+1 weeks to: 9 • determine gestational age 10 • detect multiple pregnancy 11 • screen for Down's syndrome, Edward's syndrome and Patau's 12 syndrome (see the NHS fetal anomaly screening programme).	Thank you for this comment. The committee agrees and have revised the wording in the recommendation accordingly.

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				Screening for DS, ES & PS is not integral to this offer - it is to be accepted or rejected separately from gestational age & multiple pregnancy identification It is important than sonographers recognise their role in the informed choice process	
The UK National Screening Committee (UK NSC)	Guideline	011	011	Edward's syndrome should be Edwards' syndrome	Thank you for this comment. This has been corrected.
The UK National Screening Committee (UK NSC)	guideline	013	002	In section 1.2.20, the guidance states: "At the first antenatal (booking) appointment, assess the woman's risk factors for pre-eclampsia, and advise those at risk to take aspirin in line with the section on antiplatelet agents in the NICE guideline on hypertension in pregnancy". The link provided to NICE guideline on hypertension in pregnancy only provides advice on a limited number of very high-risk factors unlike the guidance provided for risk assessment for fetal growth (section 1.2.26) which states: "Carry out a risk assessment for fetal growth restriction at the first antenatal (booking) appointment, and again in the second	Thank you for this comment. The risk assessment algorithm for pre-eclampsia provided by the Saving babies' Lives Care Bundle Version 2 is based on the NICE guideline we also refer to, therefore, we have not made the suggested reference.

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				trimester. Consider using guidance by an appropriate professional or national body, for example, the Royal College of Obstetricians and Gynaecologists' guideline on the investigation and management of the small-for-gestational-age fetus or the NHS saving babies' lives care bundle version 2". An equivalent recommendation should be made in section 1.2.20 which refers the reader to the recommendations in the NHS saving babies' lives care bundle version 2 that refer to risk assessment for preeclampsia.	
The UK National Screening Committee (UK NSC)	guideline	013	021	Recommendation 1.2.25 The UK NSC would like to inform the committee that it is in the process of updating the UK NSC recommendation on screening for pre-eclampsia (https://legacyscreening.phe.org.uk/pre-eclampsia). The review update will evaluate the evidence of the appropriateness of recommending a national population screening programme for PE (term and preterm) using a combination of maternal factors, ultrasound and biomarkers.	Thank you for this comment and the information. NICE will consider if an update to the recommendation is needed based on the UK NSC recommendation. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
The UK National Screening Committ	Guideline	033	005	Recommendations for research 4 Identification of breech presentation 5 What is the clinical and cost effectiveness of routine ultrasound from 36+0 weeks 6 compared with selective ultrasound in identifying breech presentation?	Thank you for this comment. The references systematic review was published so recently that it was not considered for inclusion in this guideline. Thank you for the information about the UK NSC's plans regarding handheld

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ee (UK NSC)				The UK NSC agrees with the suggestion that more evidence is needed to evaluate the effectiveness of routine ultrasound scans from 36 weeks compared to selective ultrasound scans. However, it would like to inform the committee that following from the recent publication of the Health Technology Assessment by Smith et al. (Smith GCS, Moraitis AA, Wastlund D, Thornton JG, Papageorghiou A, Sanders J, et al. Universal late pregnancy ultrasound screening to predict adverse outcomes in nulliparous women: a systematic review and cost-effectiveness analysis. Health Technol Assess 2021;25(15)) we are in the process of evaluating the effectiveness of handheld ultrasound devices to detect fetal presentation during routine antenatal appointments at around 36 weeks' gestational age.	ultrasound devices to detect fetal presentation. We look forward to hearing what the outcome of this process will be. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
UK Clinical Pharmacy Association (UKCPA)	Guideline	002	004-006	See 3, 8	Thank you.
UK Clinical Pharmacy Associati	Guideline	006 c	004	Add vitamin D deficiency / insufficiency as an example with smoking; as pregnancy itself is a risk factor and the pregnant woman may have additional risk factors for low Vitamin D levels	Thank you for this comment. The committee agreed not to be too prescriptive in the recommendation, however, wanted to emphasise factors that could be addressed before booking appointment, perhaps most

Stakeholder	Document	Page No	Line No	Comments	Developer's response
on (UKCPA)					importantly smoking. Furthermore, the committee agreed to add that the early pregnancy information provided at the time of referral to antenatal care should include information on for example supplements.
UK Clinical Pharmacy Association (UKCPA)	Guideline	007	006	As COVID will be with us for some time, should include here re partners and family member restrictions which may be in place; support in line with government advice at time of pregnancy NB: Addressed line 21 - use of virtual platforms as a strategy to allow communication and support for the pregnant woman.	Thank you for this comment. The scope of this guideline was developed in 2018 and the evidence reviews and recommendations were largely developed before the pandemic and COVID-19 does not generally feature in the guideline, furthermore, the guidance related to COVID-19 will likely be updated at faster pace than this guideline, therefore, no specific recommendations specific to the arrangements due to the COVID-19 pandemic have been made. However, the guideline signposts to guidance on COVID-19 and pregnancy from the Royal College of Obstetricians and Gynaecologists.
UK Clinical Pharmacy Associati	Guideline	009	005-009	Agree – reorder bullet points to start with risk in black women which is highest risk group Note: The higher risk groups are also the ones more likely to have Vitamin D deficiency status – see 2 above.	Thank you, the bullets have been reordered.

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on (UKCPA)					
UK Clinical Pharmacy Association (UKCPA)	Guideline	010	015	Eg Referral to Healthy Start Scheme if eligible	Thank you for this comment. This may be relevant yes, but we have not included any particular examples.
UK Clinical Pharmacy Association (UKCPA)	Guideline	010	022	Antenatal screening at one Trust includes Vitamin D blood test at booking for all pregnant women; effective from October 2020	Thank you for this comment and information. Screening for vitamin D deficiency was not in the remit of this guideline.
UK Clinical Pharmacy Association (UKCPA)	Guideline	013	021-022	Please clarify: Offer a urine dipstick test for proteinuria at every routine face-to-face antenatal appointment unless diagnosis of pre-eclampsia has been confirmed.	Thank you for this comment. This change was not considered necessary as the care pathway for women with pre-eclampsia will anyway differ from the routine antenatal care pathway covered by this guideline.
UK Clinical Pharmacy	Guideline	018	018	Consider adding in COVID vaccine with link to PHE advice	Thank you for this comment. Immunisation for COVID has been added as an example.

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Association (UKCPA)					
UK Clinical Pharmacy Association (UKCPA)	Guideline	022	012	NB: Shredded fresh ginger in warm water taken as a drink is a traditional remedy used in Asian communities.	Thank you for this comment. The committee decided not to comment on the specific form in which ginger could be taken because the evidence review did not compare the effectiveness of different forms and the ginger products used in the different studies varied.
UK Clinical Pharmacy Association (UKCPA)	Guideline	030	012	Need comment on use of tocolytic drugs for risk of preterm labour?	Thank you for this comment. The committee did not think this needs to be commented on in the guideline as it was not part of the scope for this guideline. The usual practice is not to give tocolytic drugs.
UK Clinical Pharmacy Association (UKCPA)	Guideline	051	001-004	We would suggest committee consider making a research recommendation comparing doxylamine/pyridoxine with other commonly used anti-emetics including metoclopramide, prochorperazine, cyclizine and promethazine	Thank you for this comment. The research recommendation made by the committee compares doxylamine/pyridoxine with other antiemetics, such as cyclizine or promethazine, prochlorperazine or chlorpromazine, metoclopramide, and ondansetron. Details of the research recommendation can be found in appendix L of evidence review R.

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Women's Health and Family Services	Evidence Review D	014	017-019	We are concerned by the lack of research/evidence/focus on the importance of the quality of relationship between the two women which is essential for successful peer support to be most impactful to the woman receiving support.	Thank you for this comment. We agree that this is an important theme, however, no evidence was identified that focused on the importance of the quality of the relationship and therefore this has not been included in the review.
Women's Health and Family Services.	Guideline	021	014	There needs to be greater clarity on the differences between doula and peer support. These are two different offerings one is a paid service and normally the other if delivered by trained volunteers. Concerned this doesn't really acknowledge the full extent of the benefits of very good peer support. However, we recognise the need for high quality research. We would be interested in hearing from the committee what it needs from research to fill in the gaps in the current research available and share our own experience of delivering peer support to vulnerable pregnant women.	Thank you for this comment. The committee did not review evidence on comparing doula support and other peer support but they did review qualitative evidence on women's experiences with non-professional (peer) support. Considering the evidence base (14 studies included), the committee did not consider recommending further research on this.

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