Consultation on draft guideline – deadline for comments 5pm on 6 July 2021 email: inducinglabourupdate@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 response from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- For copyright reasons, **do not include attachments** such as research articles, letters, or leaflets. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline.
- **We have not reviewed the evidence for the recommendations shaded in grey. Therefore, please do not submit comments relating to these recommendations as we cannot accept comments on them.**
- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. The recommendations in this guideline were largely 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. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	Women's Resource and Development Agency (WRDA)
Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry).	None
Name of person completing form	Rachel Powell (Women's Sector Lobbyist)

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Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number 'General'** for comments on whole document	**Line number 'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
1	General	General	General	Given our work on supporting and advocating for women across Northern Ireland based on their lived experience, as well as our role as the Lead on the Maternal Advocacy and Support Project across Northern Ireland, WRDA has significant concerns about the recommendation of this guideline (Inducing Labour Update [GID-NG1008]) for several reasons. Firstly, having a black or brown body does not mean you are less able to give birth. Suggesting so through these guidelines implies that being black or brown is itself a physical risk in pregnancy, rather than addressing the root causes of inequality in our health system which cause black and brown people to be vulnerable to harm. Secondly, it is widely known that interventions in birth mean a person could be more likely to experience a traumatic birth. Therefore, it can be assumed that under these proposals more black and brown people may experience traumatic births. We also know these communities are then less likely to receive support following a traumatic birth experience and that this leads to greater health inequalities later in life. Thirdly, these guidelines present induction as a 'choice', when many women and birth givers, particularly black and brown people, report never being offered a 'choice' at all, having their choices overridden, denied or their consent ignored. Many have their questions, fears and concerns dismissed or belittled. Fourthly, these proposals downplay the fact that many individuals experience induction as being more painful, and that it removes options for giving birth at home or in a birth centre. For the individual this erodes choice; but this also puts greater pressure on an already stretched system. While WRDA understands that NICE are constrained to look only at the Induction of Labour, the needs of black and brown birthing people should be looked at holistically.

				Given these points above, we do not wish to see these guidelines be published. Instead, WRDA are calling for a greater, in-depth look at the root causes for inequality black and brown pregnant people experience. In addition to the point above, WRDA are concerned with this guideline as this adopts a clinical and short-term lens and downplays evidence about women and pregnant/birthing people's experience of induction, and evidence about long term impacts. As most women go into spontaneous labour, and there is a very low absolute risk of an adverse outcome, expectant management is a very valid option at 41 weeks. Despite this, clinical intervention has been prioritised which removes the ability for the individual giving birth to make an informed decision when the risks and benefit are not clear cut, in contradiction to the Montgomery v Lanarkshire decision on appropriate counselling by healthcare professionals. With this draft guideline, NICE is overstepping its remit and presumes to make the decision about what is right for the average individual in this situation which cannot be justified by the strength of the evidence. For many women and birthing people, the quality of the conversation around induction is extremely poor, which can have significant long-term health impacts. If this recommendation proceeds it is highly likely that even more women will feel that they have no choice whether to be induced despite the positive guidance in the draft guideline on what needs to be discussed in order for a woman to make an informed choice. We are particularly concerned about the recommendation to offer induction earlier to black and brown women as well as women over 35 years of age or with a high BMI differently, despite the lack of evidence that this will improve outcomes for these groups. Finally, the guideline fails to take into account whether the recommendations are realistic to implement in practice (such as whether Trusts are able to induce this number of women), and if not, what the consequent impact on women will be. It is extremely worrying for women to be told they need to be induced or their baby will die and then have to wait 3 days before the service is able to facilitate this.
2	Guideline	4/5	S 1.1	WRDA welcomes the clear guidance here on the factors to be discussed. Women need to be told this information consistently to ensure they are aware of all factors listed here relating to induction of labour.

				Within our work on the Mas Project, many women have told us that they feel there was a lack of communication about choices that are available to them in maternity services and in relation to birthing plans. There is a need for informed choice and person -centred information provided to the person that is communicated properly in a way that is easily understood. In particular, women and birthing people are often not made aware of how long the induction process can take and alternatively are told that it can happen quickly and will be very intense. Women and birth givers should also be informed of potential options beforehand alongside the risks and benefits based on their own individual situation. The process of consent should also be discussed and the information that a woman and birth givers can withdraw consent. There is a need for greater transparency, communication, openness and clarity about options that are available to women and birth givers at earlier stages in the pregnancy so that they already have the knowledge and information before an induction scenario is presented. Women and birthing people need to be given evidence-based statistics about the likelihood of their baby dying or any other adverse outcome whether or not they choose to be induced. Often, women are simply told that their baby may die or is at increased risk of dying without having any context about the absolute or relative put around that. If a woman is informed that her baby is at risk this is an extremely distressing scenario and if this is the situation, then the reasons for this should be clearly communicated to the woman. Debriefing is a way of creating calm and reducing anxiety as well as empowering the woman with the information to make the choice that is right for her and her baby. Their individual situation should then be discussed in a person- centred and compassionate approach manner. Many women have informed us that when a healthcare professional was kind, clear and informed them with information it calmed them down and helped them feel that they were in control of the situation. Finally, women need to be told about the current existing evidence about long-term outcomes. Please add these three factors to the list of things to be discussed.
3	Guideline	5	22	WRDA wholeheartedly supports the guidance to “support the woman in whatever decision she makes”, but the guideline as a whole does not show an understanding of the power dynamics of these conversations, about the current culture of “expected compliance” in maternity services(Nicholls et

				al, EJOG, May 2019) and the evidence about the quality of conversations around induction (see for example Roberts, J. and Walsh, D. (2019) '"Babies come when they are ready": Women's experiences of resisting the medicalisation of prolonged pregnancy', *Feminism & Psychology*, 29(1), pp. 40–57. doi: 10.1177/0959353518799386.) Despite many women and birth givers feeling like they do not have a choice in relation to induction, and others feeling that they are not supported in a choice they do make, this phrase remains unchanged from the current guideline. Therefore, WRDA are concerned about the likelihood of women and birth givers feeling fully supported in their choices if this guideline is implemented. We believe that NICE must recognise the part their guideline will play in reducing the ability for women and birth givers to be able to fully make their own decisions as well as recognising that this guideline will contribute to this culture if there is a failure to recognise induction at 41 weeks as a complex choice for an individual.
4	Guideline	6	10-11	Although other organisations are best placed to comment on the clinical evidence than WRDA would be, we do not support this recommendation due to women's ongoing lived experiences shared with us with increased pain and anxiety in relation to pressure to go into labour before 41 weeks. Women and birth givers should have the option of induction at 41 weeks if that is their informed choice, but on the current evidence expectant management is an equally valid choice. Clinicians should discuss all reasonable options without bias and the decision should be the individual woman's only. Within our work on the Mas Project, many women have told us that they feel there was a lack of communication about choices that are available to them in maternity services and in relation to birthing plans. There is a need for informed choice and person -centred information provided to the person that is communicated properly in a way that is easily understood.
5	Guideline	6	14-19	These must be put in context by providing evidence-based statistics about the absolute risk of these outcomes with or without induction. This is a minimum requirement for women and birth-givers to make an informed decision.
6	Guideline	6/7	20-2	This is a very concerning recommendation. Black and brown women and birth givers, women and birth givers aged over 35 and those with higher BMIs already feel judged by maternity services and made to feel that their bodies are defective in some way.

				We are not aware of any evidence that induction improves outcomes for these groups, and none has been cited by the guideline committee. WRDA are strongly against the stereotyping or "othering" of particular ethnic groups and we very concerned about the impact this could have on the trust black and brown women have in maternity services. There are numerous examples of black and brown women not being offered any choice at all in relation to birthing plans, having their choices denied or consent overridden, and being ignored or dismissed when they raised questions or concerns about care. WRDA understands that the NICE committee is constrained in its terms of reference to look at induction only but the needs of black and brown women, and other groups who have worse outcomes need to be addressed holistically. Instead, WRDA are calling for a greater, in-depth look at the root causes for inequality black and brown women and birth givers experience throughout all maternity services.
7	Guideline	7	16-17	Whilst this is phrased as an "offer" and an "opportunity", the lived experiences of women we work with is often that they feel there was a lack of communication about choices that are available to them in maternity services and in relation to birthing plans. There is a need for informed choice and person -centred information provided to the person that is communicated properly in a way that is easily understood. The process of consent should also be discussed and the information that a woman and birth givers can withdraw consent. There is a need for greater transparency, communication, openness and clarity about options that are available to women and birth givers at earlier stages in the pregnancy so that they already have the knowledge and information before an induction scenario is presented. Without this, many women will continue to feel like this is harassment or coercion in relation to induction. Whilst it should be clear that this offer is open to women at all times, women should be asked about how often they want to revisit this discussion and their decision should be respected.
8	Guideline	13	10-11	Strongly welcome the explicit guidance to obtain consent for membrane sweeping as we are aware of a number of cases where explicit consent has not been obtained.
9	Guideline	13	16-17	This should read "Consider offering".
10	Guideline	16	12	There should be an acknowledgement here that assessing the Bishop score involves a vaginal examination for which consent needs to be obtained. You may wish to give guidance on whether it is safe to continue with an induction without this examination.

11	Guideline	General	General	Women and birth givers must be able to provide informed consent for every aspect of the birthing plan, including all stages of induction, sweeps, IV drips, pain medication and so on. Further, this guideline needs to make clear that a woman can withdraw her consent to the procedure at any point, at which point a discussion about the risks and the benefit should take place but ultimately her decision must be respected.
12	Equality Impact Assessment	General	General	The equality impact assessment has not recognised the impact of particular groups of women, namely women over 35, women with a high BMI and black and brown women of being singled out for different treatment on the back of evidence that these groups have worse outcomes in general but with no evidence that induction may improve these outcomes. Existing evidence on racial injustice suggests that black and brown women already feel they are treated as if their bodies are "different" and more "defective". The impact of this recommendation on the relationship between these groups and maternity services should be explicitly considered in the impact assessment, noting that if the guideline is followed a disproportionate percentage of these women will undergo an induction, potentially resulting in a worse birth experience in general (notwithstanding the fact that some women have a positive experience of induction).

Insert extra rows as needed

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