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| **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](http://pathways.nice.org.uk/).  **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](http://www.nice.org.uk/process/pmg22/chapter/how-you-can-get-involved)](https://www.nice.org.uk/process/pmg20/resources/developing-nice-guidelines-how-to-get-involved-2722986687/chapter/commenting-on-a-draft-guideline) 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). | Pelvic Partnership |
| Disclosure (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry). | n/a |
| Name of person completing form | Jen Campbell, co-ordinator at the Pelvic Partnership |

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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 | Guideline | General | General | The Pelvic Partnership offers support and information to women with pregnancy-related pelvic girdle pain (PGP), their families and carers. PGP affects around one in five women causing pain, immobility and associated mental health impacts.  PGP is a biomechanical joint problem that can be successfully treated with manual therapy during pregnancy and postnatally. Many women are unable to access manual therapy on the NHS and are therefore left no option but to seek treatment privately from physiotherapists, osteopaths or chiropractors – if they can afford it. Unfortunately many women have reported being unable to be treated on the NHS and afford private manual therapy, leaving them in severe pain and immobility.  Many women with PGP report that they are offered or ask for an induction due to their PGP. There is no evidence that induction for PGP has an overall benefit for women. The decision to induce may be based on the assumption that PGP is hormonal and will stop after childbirth. However, our research suggests this is not the case[[1]](#footnote-2); some women have reported having an induction as a “solution” to their PGP had gone on to have poor birth experiences and continued PGP postnatally.  If PGP is the reason for induction, we need to ensure that manual therapy and other treatment options have been attempted. Induction is not and cannot be an alternative to manual therapy to treat PGP.  As well as inductions being more expensive and riskier to the woman than manual therapy during pregnancy, we consider there is insufficient evidence supporting induction for women with PGP. If PGP can be sufficient medical cause for an induction, there needs to be evidence to support this and it needs to be applied universally across the UK for all women with PGP. |
|  | Guideline | General | General | When discussing the risks and benefits of induction with women, it is important to focus on postnatal recovery as well as the short term impact on birth. For women with PGP who may also be experiencing severe pain postnatally, the impact of induction on recovery is more significant:   * Labour positions during a monitored birth following induction   Women with PGP may be unable to move their legs apart, as such their pain free gap is much smaller and there are fewer labour positions that may be comfortable. After an induction, women are usually monitored when lying on their back, one of the most challenging birthing positions for a woman with PGP, risking more strain on her pelvis   * An epidural reduces control over her pain-free gap   If the woman has an epidural she will no longer be aware of how far she can move her legs apart without putting too much strain on her pelvis, i.e. her pain-free gap. As such, she will likely cause further strain on her pelvis, lengthening her postnatal recovery.   * Impact of the cascade of intervention   Given the higher risk of a cascade of intervention with an induction, the recovery time of an instrumentalised birth, e.g. forceps, ventouse, episiotomy or a caesarean birth is significantly higher. |
|  | Guideline | 4 | 1.1.1, 1.1.2, 1.1.3, 1.1.4 | As a charity, the Pelvic Partnership is motivated to ensure women have the tools and confidence to make informed choices about all aspects of their health, including mode of birth. We welcome the continued focus on ensuring women have access to the appropriate information to make such important decisions, in consultation with their healthcare professionals, at all stages of their pregnancy.  When discussing induction this needs to be timely, accessible, appropriate and respectful of the woman’s wishes and include a full and thorough discussion including the risks and higher chances of a cascade of intervention or caesarean birth, both of which necessitate a longer postnatal recovery time.  For women with PGP, this discussion also needs to consider the woman’s access to manual therapy to treat her PGP; if she remains in pain and has not received manual therapy, decisions about induction may be made through a different lens, possibly being perceived as a solution to her PGP (see above).  Induction is not and cannot be an alternative to manual therapy to treat PGP.  It’s also worth underlining the importance of the communication between healthcare professional and the woman being equal, balanced and fair so that the woman feels able to have a different opinion on her mode of birth. Consultation with our service users in 2018 showed that over 40% of women surveyed felt they weren’t taken seriously in discussing their PGP with their healthcare professional[[2]](#footnote-3), implying that many women may feel unable to go against the suggestions of the team caring for them. |
|  | Guideline | 17 | 1.2.2, 1.2.3, 1.2.4 | We are very concerned with the proposal to bring forward induction for all women.  As the guideline states in 1.2.1, labour usually starts naturally by 42+0 weeks and discussing instrumental methods to start labour too early risks encouraging women to induce unnecessarily. We recognise that the committee stated there “was not enough evidence to identify the optimal timing of induction more precisely and so the committee made a research recommendation” (Page 24, Inducing labour DRAFT guideline).  We would strongly encourage the recommendations to stay as for the 2008 guideline, pending the results of this research. |
|  | Guideline | 17 | 1.2.3, 1.2.4 | As well as the recommendation for induction form 41+0 for general singleton pregnancies we are particularly concerned about the move to recommend induction for women who are 39+0 with uncomplicated singleton pregnancies due to their ethnicity, age, weight, and if they had support conceiving.    By focusing on these factors during the pregnancy and underlining the perceived (see below) risk factors with these characteristics, additional stress and anxiety is placed upon the woman, encouraging her to make decisions regarding an instrumental birth and implying that this is due to her age, ethnicity and weight.  We are very concerned about the statement in the guideline that “the committee noted that **in their knowledge and experience** women from the Black, Asian and minority ethnic family background, women with BMI of 30 or more, women aged 35 years or more and women who had assisted conception were at a higher risk of adverse events in a pregnancy that was prolonged beyond term” (our emphasis, Page 24, Inducing labour DRAFT guideline). As such, we consider there is insufficient scientific evidence and should not be included in the guidance. |
|  | Guideline | 6-12 | 1.2, 1.2.18 | We welcome clarity around the medical grounds for an induction and the process induction by maternal request.  Many women with PGP report that they are offered or ask for an induction due to their PGP, although for some women and healthcare professionals this is based on the assumption that PGP is hormonal and will stop after childbirth. Furthermore, some women who have had an induction as a “solution” to their PGP had gone on to have poor birth experiences and continued PGP postnatally[[3]](#footnote-4).  If PGP is the reason for induction, we need to ensure that manual therapy and other treatment options have been attempted. Induction is not and cannot be an alternative to manual therapy to treat PGP.  In addition, if PGP can be sufficient medical cause for an induction, there needs to be evidence to support this and it needs to be applied universally across the UK for all women with PGP. |
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1. Over 50% of women we surveyed in June 2018 continued to experience PGP postnatally (Pelvic Partnership Survey, June 2018, Data available at [www.pelvicpartnership.org.uk/womens-health-strategy/](http://www.pelvicpartnership.org.uk/womens-health-strategy/)) [↑](#footnote-ref-2)
2. Pelvic Partnership survey, June 2018, Data available at [www.pelvicpartnership.org.uk/womens-health-strategy/](http://www.pelvicpartnership.org.uk/womens-health-strategy/) [↑](#footnote-ref-3)
3. Over 50% of women we surveyed in June 2018 continued to experience PGP postnatally (Pelvic Partnership Survey, June 2018, Data available at [www.pelvicpartnership.org.uk/womens-health-strategy/](http://www.pelvicpartnership.org.uk/womens-health-strategy/)) [↑](#footnote-ref-4)