Postnatal Care

Consultation on draft guideline - Stakeholder comments table
16/10/2020 – 25/11/2020

Stakeholder	Document	Page No	Line No	Comments	Developer's response
Action on Smoking and Health	Guideline	6	7	This guideline should specifically reference the importance of sharing information about the mother's smoking status during the transfer of care, and what support, if any, is required to help them quit smoking or maintain a quit and keep a smokefree home. Babies who are exposed to tobacco smoke during pregnancy or after birth have a higher risk of sudden infant death (SIDS), asthma, chest infections, and meningitis.[i] For new mothers, quitting smoking will reduce their risk of adverse outcomes during any future pregnancies, as well as reducing their risk of chronic diseases like cancer, lung or heart disease.1 Recording data on a woman's smoking status throughout pregnancy is a requirement of the Saving Babies' Lives Care Bundle[ii] and NICE guidelines PH26[iii] and PH48.[iv] It is estimated that up to 76% of women who manage to quit smoking when they are pregnant relapse after giving birth.[v] Consequently, it is vital that data on smoking status is routinely shared during the transition from midwifery to health visitor care to ensure that women who have managed to quit smoking during pregnancy do not relapse. In addition, smoking is a known risk factor for venous thromboembolism (VTE) during pregnancy and up to six weeks following pregnancy.[vi] VTE is a leading cause of deaths and disability in the UK.[vii] Failure to diagnose a	Thank you for your comment. The committee agrees with the importance of helping the family to maintain a smokefree environment for the baby. The committee added this point to another section of the guideline as they agreed it is very important. The committee decided not to add this level of detail into the recommendation about communication about transfer of care between healthcare professionals, however, the committee added a line about sharing the plan of ongoing care, including long-term management. This could well include information about smoking/smoking cessation.

				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.7 The health visiting team should be made aware of women's smoking status ahead of the new birth visit to ensure that they are aware of elevated risk of VTE and can prepare accordingly.	
Action on Smoking and Health	Guideline	7	002 - 003	This guideline should specifically reference the importance of delivering advice about secondhand smoke and smokefree homes to mothers and their partners or household members. The home environment plays a crucial role in whether women are smoking at conception, if they are able to quit successfully, whether they relapse to smoking once the baby is born and if they and the baby are exposed to secondhand smoke. 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.[viii] An estimated 20% of women are also exposed to secondhand smoke in the home throughout their pregnancy, leading to many of the same adverse birth outcomes experienced by women who smoke.[ix] 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	Thank you for your comment. The committee agrees about the importance of this issue and have added to this to another recommendation about information for parents in relation to caring for the baby that parents should be given information about maintaining a smoke-free environment for the baby (and added a cross reference to the NICE guideline on smoking: stopping in pregnancy and after childbirth).

				car.3 The NHS Long Term Plan's commitment to include pregnant women's partners in the tobacco dependence treatment pathway recognises that women's environments have a crucial impact on their smoking.[x] There is some evidence to suggest that household-level interventions can be effective for engaging women and their smoking partners, as they frame smoking as a household responsibility with family-wide impact.[xi] [xii]Trials in Greater Manchester and Poole have found that women are more likely to quit smoking if they are supported by their partner or a significant other.[xiii]	
Action on Smoking and Health	Guideline	007 008	023 - 027 001 - 002	The guideline should specifically set out the "addition support" required for women with complex social factors, with specifically reference to smoking cessation support. Women aged under 20 and those living in poverty are both classified as having complex social factors by NICE.[xiv] Both of these groups have significantly above average smoking rates which correspond with higher rates of infant mortality than the general population.[xv] In 2018/19, 30% of women aged under-20 were current smokers at their booking appointment compared to just 6% of women over the age of 40.[xvi] Additionally, 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.[xvii] Booking data from 2018/19 shows that smoking rates among	Thank you for your comment. The committee agrees that smoking cessation support is an important issue and we have made a reference to the NICE guideline on smoking: stopping in pregnancy and after childbirth in the recommendations. We have also now added to the guideline about providing information to the parents (as both parents smoking status is important) about maintaining a smoke-free environment for the baby.

				women in the most deprived decile are over five times greater than those in the least deprived decile (24% and 4.3% respectively), with a clear gradient across the deciles.[xviii] It is therefore essential that healthcare professionals dealing with women postnatally are equipped to deliver stop smoking interventions, in line with NICE guidance on smoking. All health visitors and midwives should receive training on carbon monoxide (CO) monitoring to assess smoking status, delivering very brief advice (VBA), and referring women to specialist stop smoking support.	
Action on Smoking and Health	Guideline	8	005 - 021	We are concerned that the use of the phrase 'topics to discuss may include' implies that asking about smoking status is optional. Pregnancy and the first few months of a child's life are a crucial opportunity for behaviour change. It is estimated that up to 76% of women who quit when they are pregnant relapse after giving birth.5 This risks exposing newborn babies to secondhand smoke, significantly increasing their risk of Sudden Infant Death Syndrome (SIDS), chest infections, asthma and meningitis.1 Additionally, booking data from 2018/19 shows that women are more likely to smoke during subsequent pregnancies than they are during their first pregnancy.[xix] This makes preventing mothers from taking up or relapsing to smoking postnatally especially important to reduce their chances of miscarriage, stillbirth, or other adverse birth outcomes during future	Thank you for your comment. The list of topics to discuss needs to be individualised and discussion around smoking at every postnatal contact is not necessarily relevant to all women. The committee agrees about the importance of this issue and about providing a smoke-free environment for the baby. We have therefore added this to a recommendation about information provision to parents in relation to care of their baby.

				pregnancies. Additionally, growing up in a smoking household nearly triples the likelihood that a child will become a smoker themselves,[xx] with smoking the leading cause of preventable, premature death in England and responsible for approximately half a million hospital admissions each year.[xxi] The guideline should recommend that all new mothers are asked about their smoking status, receive brief advice on smoking, and be referred to stop smoking support. This conversation should include advice on keeping a smokefree home for parents who are not willing to quit smoking.	
Action on Smoking and Health	Guideline	15	007 - 020	This guideline should recommend that health professionals give all parents information on: The harms of secondhand smoke to babies and children; The harms of smoking or exposure to secondhand smoke during future pregnancies; Practical advice on how to keep homes smokefree; Offer of referral to local stop smoking services. There is no risk-free level of secondhand smoke exposure, especially for children.[xxii] Evidence has shown that infants and children of parents who smoke are twice as likely to suffer from a severe respiratory infection as the children of non-smokers.[xxiii] It is essential that all parents must be given clear messaging around the harms of smoking and secondhand smoke exposure and the importance of maintaining a smokefree home. Emphasising that the only effective way of reducing exposure is to make homes and vehicles completely smokefree, as	Thank you for your comment. The committee agree with you about the importance of maintaining a smoke free environment for the baby. They therefore added to this recommendation to say that parents should be given information about maintaining a smoke free environment and they also cross referenced to the NICE guideline on smoking, specifically the section on stopping smoking in pregnancy and after childbirth.

				ventilation or limiting smoking to certain areas do not provide sufficient protection. Additionally, healthcare professionals, in contact with families, should be delivering very brief advice on smoking and referring to local stop smoking services to motivate, and support quit attempts.	
Association for Improvements in the Maternity Services	Guideline	1	5	We suggest checking whether the wording "and this should be taken to include people who do not identify as women but who have given birth" is acceptable to the LGBTQ+ community. It is our understanding that the term 'all birthing people' is to be preferred.	Thank you for your comment. We have revised the wording.
Association for Improvements in the Maternity Services	Guideline	4	1	Recommendations The statement "People have the right to be involved in discussions and make informed decisions about their care" should more accurately say "People have the right to be given the information that they need to make informed decisions about their care, and to have those decisions respected" to reflect the legal principle of autonomy (see www.birthrights.org.uk/factsheets/consenting-to-treatment/)	Thank you for your comment. This is a standard text used by NICE and we have passed your comment to NICE.
Association for Improvements in the Maternity Services	Guideline	4	1	Recommendations The statement "Parents and carers have the right to be involved in planning and making decisions about their baby's health and care" should more accurately say "Parents and carers have the right to make decisions about their baby's health and care" as confirmed in NHS guidance (see	Thank you for your comment. This is a standard text used by NICE and we have passed your comment to NICE.

				www.nhs.uk/conditions/consent-to-treatment/children/)	
Association for Improvements in the Maternity Services	Guideline	4	005 - 013	Timing of transfer to home care This section does not address the needs of those who have birthed at home and will therefore not be “transferring” there. The guideline needs to specify what checks should be offered and what information should be given to the woman/both parents/other supporters by a midwife who has attended a homebirth before she leaves, and what the arrangements and timing should be for other checks, such as the baby’s physical check, if these need to be done at a later point.	Thank you for your comment. The committee agrees and have changed the wording in this section to reflect this, the checks before transfer from the maternity unit and after home birth before the midwife leaves should be the same.
Association for Improvements in the Maternity Services	Guideline	4	005 - 013	Timing of transfer to home care It is not clear to us whether any variations need to be made to the recommendations in the case of women having an early discharge direct from the birthing room, so we ask the Guideline Development Group to consider this.	Thank you for your comment. We recognise that early discharge sometimes happen, however, the same checks should still be done before transfer to community care.
Association for Improvements in the Maternity Services	Guideline	4	005 - 013	Section 1.1 Organisation and delivery of postnatal care Timing of transfer to home To reflect the fact that, in accordance with the legal principle of autonomy (see www.birthrights.org.uk/factsheets/consenting-to-treatment/), decisions are for the woman to make, and in line with the wording used in other NICE guidelines that care is something that should be offered we suggest this section is reworded as shown below. “Discuss with the woman when she will feel ready to return home and provide	Thank you for your comment. The recommendations emphasise the need to discuss the timing of transfer to community care with the woman and we have revised the wording of this recommendation to emphasise the importance of woman's preferences. However, there may be different clinical reasons why transfer might not always be possible based on her preferences alone.

				the support and information she needs in order to make this decision. This should include offering the following checks:	
Association for Improvements in the Maternity Services	Guideline	4	009 - 012	We suggest adding the point about passage of meconium to our proposed new section on "Information to be provided before transfer home/departure of midwife after homebirth" where it fits more naturally with other information to be given. Here the wording could then be simply: assess her baby's health (physical check, general behaviour check and whether the baby has passed meconium)"	Thank you for your comment. We have revised the section to cover departure of midwife after home birth as such suggested. We think it's important that the parents are advised about the meconium as many babies will be home when this happens.
Association for Improvements in the Maternity Services	Guideline	4	13	We do not believe that observing one feed is sufficient to ensure that a mother is able to feed her baby confidently; and we believe that parents need to be aware whether their baby has a tongue-tie so that they know to seek help for it promptly if it is causing feeding problems. We suggest this point should say: assessment of feeding effectiveness by observing at least two feeds and checking for tongue-tie"	Thank you for your comment. Observing one effective feed (we have now added a definition of this) before transfer to community care is not necessarily an indication that a mother is able to feed her baby confidently, therefore it is important that feeding is also assessed and discussed at every midwife visit, as recommended. The guideline recommends that feeding is observed once within 24 hours of birth and at least once more within the first week. Additional observations may be needed, including checking for tongue-tie if there are concerns.
Association for Improvements in the Maternity Services	Guideline	5	003 - 006	To reflect the importance of the woman's views we suggest 1.1.2 should say: "Discuss with the woman her preferred timing for transfer to home care, taking into account the factors in recommendation 1.1.1, the support available to her and any concerns, including any safeguarding issues (also see the NICE guideline on domestic violence 6	Thank you for your comment. We have revised the wording of this recommendation to emphasise the importance of taking into account the woman's preferences in addition to the clinical and other considerations.

				and abuse), and support her transfer to home in line with her wishes"	
Association for Improvements in the Maternity Services	Guideline	5	6	We feel that it is vital for the guideline to make recommendations about information that should be given before discharge (or before the midwife leaves in the case of a homebirth). This is both to ensure that parents/other supporters feel confident about caring for the baby and to ensure that they are aware of signs of serious problems which might develop before the midwife's first visit. The information should include details of who parents/supporters should contact if they have concerns during this time. In order for fathers/partners or other supporters (if the woman wishes to involve them) to be empowered to support the woman and to be involved in the care of the baby, they need to be offered the same information as women. Fathers/partners/other supporters also need to be aware of problems with their own mental health and well-being, and where they can seek support, as this can impact negatively on the family unit. We therefore recommend the addition of the following section: Information to be provided before transfer home/departure of midwife after homebirthIn accordance with the woman's wishes for who should be involved, give the woman, the father/other partner and/or other supporter(s) the following: Information about signs to be aware of which might indicate a problem with the baby's health or well-being and who to contact in this situation including:	Thank you for your comment. We have added a recommendation about giving information before transfer of care to community care or before the departure of the midwife after home birth, including the postnatal period and what to expect, what support is available and who to contact if any concerns at different stages. We recognise the importance of partners' involvement which is why we have made the recommendation about involving them according to the woman's wishes. In terms of baby's care, we generally refer to the parents, instead of only the mother.

				if the baby has not passed meconium, advise that if the baby does not do so within 24 hours of birth, they should seek advice from a healthcare professional (also see recommendation 1.3.11) Information about caring for the baby (as in section 1.3.9) Information about signs to be aware of which might indicate a problem with the woman's physical health and who to contact in this situation Information about signs to be aware of which might indicate a problem with either parent's mental health and well-being, and who to contact in this situation Information on where to seek support for any problems including feeding problems or concerns should be provided in an easy-to-find format e.g. printed on maternity notes	
Association for Improvements in the Maternity Services	Guideline	5	009 - 012	First midwife visit after transfer of care from the place of birth or after a home birth Given that there is no research evidence about the timing of the first visit, we feel strongly that it is not appropriate to set a lower limit of 12 hours after mother and baby are home. Some families will be in need of support (e.g. with breastfeeding issues or health concerns) much sooner than that, so we feel that the timing needs to be flexible to meet individual needs. In order to respect "the woman's circumstances and preferences" as well as any need for early support while allowing midwives the necessary flexibility to manage their workload we suggest this should say: "Offer to arrange the first postnatal visit by a midwife in a place, within an agreed time window (e.g. morning or	Thank you for your comment. The committee revised the recommendation to say within 36 hours (instead of 12 to 36 hours). The recommendation gives a window within which the visit should happen and the committee agrees that individual considerations may be needed in regards to the exact timings.

				afternoon) and within a time frame that meets the woman's needs, at the latest by 36 hours after she and her baby have returned home or after a home birth."	
Association for Improvements in the Maternity Services	Guideline	7	4	We welcome the reminder to "use clear language" but feel it is more helpful to say, "use plain English rather than clinical terms". It is our perception that midwives often use what are to them everyday terms, but which can be baffling to lay people.	Thank you for your comment. We think that "use clear language" conveys this point well enough and we have not made a change.
Association for Improvements in the Maternity Services	Guideline	7	006 - 007	In order to comply with the legal principle of autonomy (www.birthrights.org.uk/factsheets/consenting-to-treatment/), rather than saying that "Information should support shared decision making" this should say "Provide the woman with the information that she wants in order to make informed decisions about her and her baby's care."	Thank you for your comment. According to NICE "Shared decision making is when health professionals and patients work together. This puts people at the centre of decisions about their own treatment and care." (https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making) People have the right to make choices about their care but the shared decision making principles also highlight the responsibility that the healthcare professionals have on providing accurate information about the different options and their benefits and harms. Therefore, we think 'shared decision making' is appropriate in this instance and we have not changed the wording.
Association for Improvements in the Maternity Services	Guideline	7	007 - 011	Communication with women This is to emphasise the importance of health care professionals listening to women we suggest opening this section with the statement: "Women should be listened to and recognised as experts in their own physical and mental health."	Thank you for your comment. We have added a recommendation in this section (now titles 'Principles of care') about listening to the women and being responsive to her needs and preferences.

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Association for Improvements in the Maternity Services	Guideline	7	007 - 011	Communication with women To reflect the important role of many partners/other supporters in caring for the woman and baby we suggest expanding 1.1.7 to say "...involve them according to the woman's wishes. If it is acceptable to the women to involve her partner or other supporter(s), the partner/supporter(s) should be provided with the information and support they want to help them care for the woman, the baby and themselves."	Thank you for your comment. We recognise the important role that partners play and we think the specific recommendation about involving the woman's partner according to her wishes covers this already. The focus of the guideline is providing care for the woman and her baby. We have made some revisions to the guideline to clarify that in relation to the care of the baby, we generally refer to the parents, not just the woman.
Association for Improvements in the Maternity Services	Guideline	8	5	1.2 Postnatal care of the woman We suggest that this is reworded to make clear that there should be a discussion of these points before discharge from hospital/birth centre or before a midwife leaves after a homebirth (as in our suggested new section Information to be provided before transfer home/departure of midwife after homebirth). If the first postnatal visit does not take place for up to 36 hours it could be too late to be warning someone about "symptoms and signs of potential postnatal mental health and physical problems" which had already arisen.	Thank you for your comment. We have added a recommendation about information that should be provided before transfer of care from the maternity unit to community care, or before the midwife leaves after a home birth. This should include information about the postnatal period and what to expect, what support is available and who to contact if there are concerns.
Association for Improvements in the Maternity Services	Guideline	9	005 - 015	1.2 Postnatal care of the woman Pelvic floor dysfunction can be a significant issue for women and contribute to poor mental health in the postnatal period. We believe it would be beneficial for all women to be routinely asked about their experience of pelvic floor dysfunction, and referred to a physiotherapist if appropriate, and this should be added to the list.	Thank you for your comment. Assessment of bladder and bowel function and perineal health are included in the routine assessments for the woman. We have also added about providing information about the importance of pelvic floor exercises and when to seek help. In the recommendation about the 6-8 week postnatal check by a GP, we have also specifically mentioned referral to physiotherapy if needed. The NICE guideline on pelvic floor dysfunction is

					currently being developed and will publish after the postnatal care guideline. A cross reference to the pelvic floor dysfunction guideline can be added to the postnatal care guideline as a post-publication edit once the former is published.
Association for Improvements in the Maternity Services	Guideline	10	006 - 007	1.2 Postnatal care of the woman We are pleased to see the inclusion of this recommendation: “At each postnatal contact, give the woman the opportunity to talk about her birth experience”. We also believe that a specific offer of a chance to talk through the birth with a suitably experienced person, and signposting to appropriate support in relation to this, should be a routine part of postnatal care. We would like to see the guideline recommend this.	Thank you for your comment. The recommendation already includes providing information about relevant support and we have specifically added "birth reflection services" to the recommendation.
Association for Improvements in the Maternity Services	Guideline	10	006 - 007	We suggest adding to this section a recommendation that all women should also be advised on the resolution and complaints process to deal with any concerns they have about their care, as well as signposting to their local Maternity Voices Partnership as a means of allowing them to contribute to the good functioning of their local maternity services.	Thank you for your comment. The NICE guideline on Patient experience in adult NHS services, which we refer to in the guideline, already covers the issue about complaints processes and giving feedback about their care (see recommendations 1.3.12 and 1.3.13 in CG138). The recommendation already covers providing information about relevant support services.
Association for Improvements in the Maternity Services	Guideline	10	006 - 007	We suggest adding to this section a recommendation for PTSD screening to be carried out on all women, and for access to treatment for PTSD to be made available in a timely manner to all women who require it.	Thank you for your comment. We have added a reference to the NICE guideline on antenatal and postnatal mental health which has a section on birth trauma and the NICE guideline on PTSD.
Association for Improvements in the Maternity Services	Guideline	12	018 - 019	Perineal pain Pain from stitches can be a significant issue for women and contribute to poor mental health in the postnatal period. We therefore believe the guideline should	Thank you for your comment. We think that pain from stitches and concerns with stiches is captured by the assessment of perineal pain and healing.

				specify that, as well as assessing perineal wound healing, asking the woman about and assessing problems with stitches should form part of routine care.	
Association for Improvements in the Maternity Services	Guideline	13	016 - 018	1.3 Postnatal care of the baby 1.3.1 To reflect the importance of involving fathers/partners or other supporters in care of the baby we suggest adding “At each postnatal contact, ask both parents (if present)/other supporters if there are any concerns about the baby’s general wellbeing, feeding or development.”	Thank you for your comment. We agree and have changed the wording to say "parents" where appropriate. We have also added a definition for the term "parents".
Association for Improvements in the Maternity Services	Guideline	16	003 - 004	Bed sharing 1.3.12 add “rather than face down or on their side” in line with guidance from The Lullaby Trust	Thank you for this suggestion, which the committee agreed to make.
Association for Improvements in the Maternity Services	Guideline	16	6	Bed sharing 1.3.12 Add recommendation not to use sleep positioners, in line with guidance from The Lullaby Trust	Thank you for your comment. We did not think this addition was necessary in relating to advice on safer bed sharing, it was not identified in the evidence review. We have added a mention of established safer sleeping guidance to a recommendation about providing information to parents about caring for their baby. In the rationale and impact section we provide some examples of sources for this guidance, including the Lullaby Trust.
Association for Improvements in the Maternity Services	Guideline	16	10	Bed sharing 1.3.13 should read “have drunk alcohol”, in line with guidance from The Lullaby Trust	Thank you for your comment. We are not reproducing guidance by the Lullaby Trust and the 2 units of alcohol is based on the evidence reviewed (see evidence review N).
Association for Improvements in the Maternity Services	Guideline	16	13	Bed sharing 1.3.13 add the following, in line with guidance from The Lullaby Trust: extreme tiredness premature - 37 weeks or less low birth weight - 2.5kgs	Thank you for your comment. We have added low birth weight to the recommendation as suggested because it is a well-known risk factor, however, preterm babies were outside the scope of this

					guideline and therefore have not been mentioned in the recommendation. We have clarified this in the rationale and impact section. Extreme tiredness was not something that we reviewed evidence on and therefore cannot comment.
Association for Improvements in the Maternity Services	Guideline	21	012 - 019	Role of the healthcare professional supporting breastfeeding We are pleased to see the focus on the breastfeeding knowledge required by Healthcare professionals caring for women and babies in the postnatal period. In addition, we would like to see recommendations for healthcare professionals to have up to date knowledge about: Which medications which can safely be taken by breastfeeding mothers (e.g. which anti-depressants are safe to take) Normal breastfeeding issues, such as cluster feeding Potential breastfeeding problems, such as tongue tie How to express and store breastmilk safely (e.g., sterilising equipment) Re-lactation	Thank you for your suggestions, which the committee discussed. They agreed to edit this recommendation, which now makes reference to medicine use and breastfeeding, re-lactation and preparation and safe storage of expressed breastmilk. They were unable to reference tongue tie because this is outside the scope of the guideline and they did not make explicit reference to 'cluster feeding' although the recommendation does refer to responsive feeding and strategies to manage fatigue. Finally, it is important to understand that this list was not intended to be exhaustive, but instead provides suggestions for discussion topics to cover during the provision of information, advice and reassurance about breastfeeding.
Association for Improvements in the Maternity Services	Guideline	23	009 - 030	Giving information about breastfeeding This should include accurate information on Which medications which can safely be taken by breastfeeding mothers (e.g. which anti-depressants are safe to take) Normal breastfeeding issues, such as cluster feeding Potential breastfeeding problems, such as tongue tie How to express and store breastmilk safely (e.g., sterilising equipment) Re-lactation Plus information on sources of information and support.	Thank you for your suggestions, which the committee discussed. They agreed to edit this recommendation, which now makes reference to medicine use and breastfeeding, re-lactation and preparation and safe storage of expressed breast milk. They were unable to reference tongue tie because this is outside the scope of the guideline and they did not make explicit reference to 'cluster feeding' although the recommendation does refer to responsive

					feeding and strategies to manage fatigue. Finally, it is important to understand that this list was not intended to be exhaustive, but instead provides suggestions for discussion topics to cover during the provision of information, advice and reassurance about breastfeeding.
Association for Improvements in the Maternity Services	Guideline	25	004 - 011	Formula feeding We suggest this section should include discussion of combination feeding as an alternative to either exclusive breastfeeding or exclusive formula feeding, to enable women to understand the full range of feeding options available to them.	Thank you for your comment. We have added a statement about this into the first recommendation of this section.
Association for Improvements in the Maternity Services	Guideline	General	General	We were disappointed to see that there is no mention of how the current policy shift towards embedding a full pathway Continuity of Carer model of care is impacting on the delivery of postnatal care. We are not clear whether this issue was considered in your discussions: if not, we would call on the Guideline Development Group to look at this. If it was, and no research was found on this issue, then we would call on the Guideline Development Group to include a research recommendation. We know anecdotally that many issues that arise during the postnatal period would be better addressed within a continuity of carer model of care.	Thank you for your comment. Evidence on effectiveness and impact of continuity of carer was not reviewed by the guideline committee as it was not part of the scope for this guideline. Because we did not search for evidence on this, we are not able to recommend research on this either. However, qualitative evidence in relation to breastfeeding support highlighted that women valued this and this was captured in the recommendations. This aligns with the NHS Better Births report.
Association for Improvements in the Maternity Services	Guideline	General	General	We welcome the focus on women's information needs in the postnatal period, but are concerned that the document ignores the important role that most fathers/partners (or in some cases other family members or friends) play in supporting the well-being of both the woman and the baby; We have	Thank you for your comment. The focus of this guideline is on the care of the woman and the baby. We recognise the important role that the partner can have, however, they are generally not the focus of this guideline. The sections relating to the care of the baby generally address parents instead of just the

				indicated below some specific sections where we would like to see the information needs of fathers/partners or other supporters included but ask the Guideline Development Group to revisit the whole document with this in mind.	mother as we recognise the role that the father/mother's partner might have in the baby's care. We have now also acknowledged in the recommendations that those with parental responsibility have the right to be involved in the care of the baby. Please see responses to your other comments relating to specific sections.
Association for Improvements in the Maternity Services	Guideline	General	General	We welcome the focus on women's mental health needs in the postnatal period but we are concerned that the document ignores the fact that the mental well-being of fathers/partners/other supporters can potentially have a serious impact on the whole family unit, and we believe that this also needs to be addressed in the guideline. We have indicated below some specific sections where we would like to see the support needs of fathers/partners or other supporters included but ask the Guideline Development Group to revisit the whole document with this in mind.	Thank you for your comment. The focus of this guideline is on the care of the woman and the baby. We recognise that the partner's mental wellbeing may have an important impact on the woman and the baby, however, they are generally not the focus of this guideline. We do think, however, that any particular concerns relating to the partner's mental health which might impact the woman's and baby's wellbeing could be captured by the discussions and assessments that the healthcare professional has with the woman/family. Please see responses to your other comments relating to specific sections.
Association for Improvements in the Maternity Services	Guideline	General	General	We are concerned by the paternalistic tone of the guidance which fails to recognise that people have a legal right to make decisions about their own care (see www.birthrights.org.uk/factsheets/consenting-to-treatment) and that parents have the right to make decisions about their baby's care except in unusual circumstances where a court has ordered otherwise (see www.nhs.uk/conditions/consent-to-treatment/children). We have highlighted below some specific sections which we think	Thank you for your comment. The committee revised the wording where considered appropriate based on your and other stakeholders' feedback. Please see responses to your other comments related to specific sections.

				should be reworded to reflect these rights but ask the Guideline Development Group to revisit the whole document with this in mind.	
Association for Improvements in the Maternity Services	Guideline	General	General	The guideline appears to assume that all women birth in a 'maternity unit', spend time on a postnatal ward and later transfer home. The recommendations about the timing of checks and information-giving, as well as the timing of the first home visit, are therefore not always appropriate for women who have birthed at home, or for those having an early discharge direct from their birthing room. We have highlighted below some specific sections which we think need to be reworded to include these different models but ask the Guideline Development Group to revisit the whole document with this in mind.	Thank you for your comment. We have revised the wording in this section so that it captures those who give birth in a maternity unit/hospital as well home births. Please see responses to your other comments on specific points.
Association for Improvements in the Maternity Services	Guideline	Other	General	We believe that the guideline should include a section for parents of babies in NICU/SCBU including recommendations for the information they should be given about; What to expect Feeding/tube-feeding; expressing breastmilk; use of donor milk if appropriate How they can be involved in caring for baby including the benefits 'Kangaroo care' How to protect their own mental health	Thank you for your comment. Specialist care is outside the scope of this guideline so these issues have not been covered.
Association of Breastfeeding Mothers	Guideline	6	3	The suggestion that a health visitor visits one to two weeks after discharge from the midwife is a concern as mothers and babies struggling could be left at risk. This time frame should be individualised based on professional assessment and conversation between the midwife and health visiting service taking into account parent views.	Thank you for your comment. The reason for the timeframe suggested in this recommendation is to spread the visits during the first 8 weeks more evenly so that the family is not left without a visit by a healthcare professional for many weeks during the first weeks after birth. The committee's concern was that in current

				Sometimes an immediate handover would be appropriate, sometimes a longer gap. There should be reference to involvement of peer support options at this early stage. There may be issues with breast refusal at this stage and a specific reference to signposting when babies are not attaching or struggling to attach.	practice, there is often a gap of even 6 weeks between the first health visitor visit and the second postnatal health visitor visit and this may risk not identifying concerns, including mental health concerns in a timely manner. The recommendation to consider spreading the visits more evenly is in the interest of the family. We have also added a recommendation about ensuring that the transfer of care between midwifery and health visitors are clearly communicated between the healthcare professionals and the to the woman/family so that there is no uncertainties, this will also allow for the timing to be tailored if needed. Furthermore, we have added a recommendation about giving information about available support during the postnatal period, including statutory and voluntary services. In relation to breastfeeding, we have added that referral to additional support should be considered. The recommendations already stated that information about available peer support should be provided.
Association of Breastfeeding Mothers	Guideline	6	19	The transfer of care conversation would benefit from a specific reference to information around feeding and a discussion of any challenges/ issues.	Thank you for your comment. We have added this to the recommendation.
Association of Breastfeeding Mothers	Guideline	9	12	Add specific reference to mastitis to ‘symptoms of inflammation’	Thank you for your comment. The committee discussed your suggestion and agreed to edit that particular bullet point to now read "nipple and breast discomfort and symptoms of inflammation". They also added a new bullet point to a subsequent recommendation about the first postnatal midwife visit, stating

					that the woman should be informed about the need for further medical advice if there are worsening signs or symptoms which could indicate mastitis.
Association of Breastfeeding Mothers	Guideline	15	10	'references to planning and managing babies' feeding would benefit from link to UNICEF Baby Friendly standards. These are now agreed as the goal for all maternity services as referenced in the NHS long term plan. These resources e.g. the feeding assessment resources, should be considered the professional expectation.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
Association of Breastfeeding Mothers	Guideline	16	001 - 013	Really positive to see this reference to bed sharing which will support evidence-based conversations with families. Just have a concern around reference to 2 units of alcohol being considered a safe limit as this will be very individual i.e. 2 shots of whiskey on an empty stomach of a 7 stone woman versus 1 large glass of wine alongside a slow meal on a larger person.	Thank you for your comment. This element of the recommendation was based on the evidence included in the review and supported by committee expertise. There was no evidence that parents should be advised not to share a bed with their baby if any alcohol at all had been consumed. The committee therefore made no change to this recommendation based on your comment.
Association of Breastfeeding Mothers	Guideline	17	2	Good to see references to emotional attachment. UNICEF Baby Friendly standards are useful here with resources for families and professionals.	Thank you for your comment.
Association of Breastfeeding Mothers	Guideline	17	15	To state 'feeding' is a challenge to emotional attachment is confusing. Feeding is often a huge positive in the development of the relationship between parent and child. Should this say 'challenges with feeding'?	Thank you for your comment. The committee agree with the point you make and have therefore changed the recommendation, which now refers to 'feeding concerns' as a potential challenge which may affect bonding and emotional attachment.
Association of Breastfeeding Mothers	Guideline	17	21	Add reference to a history of mental health issues separately.	Thank you for your comment. We have revised this to say complex psychosocial needs which could include history of mental health issues.

Association of Breastfeeding Mothers	Guideline	20	10	Reference to UNICEF Baby Friendly standards to support conversations around feeding	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
Association of Breastfeeding Mothers	Guideline	20	15	Nutritional benefits as a first bullet point feels prescriptive. The outline of the conversation should be more open and encourage professionals to explore what parents may already know and to be able to raise issues rather than a fact delivery process.	Thank you for your comment. The order of the bullets do not imply order of importance and the individual healthcare professionals can choose for themselves how exactly to discuss these issues with parents.
Association of Breastfeeding Mothers	Guideline	21	3	'soothe and comfort the baby' implies there aren't emotional/ psychological benefits for the mother. Mother breastfeeding also benefits from the oxytocin release and the mental health benefits are well-evidenced. It is comfort for both members of the dyad.	Thank you for your comment. There may be various benefits to both mother and baby both physiologically and psychologically, however, we have not attempted to provide an exhaustive list here.
Association of Breastfeeding Mothers	Guideline	21	4	Reference to partners is very welcome. Partners benefit from knowing some of the details of how breastfeeding works e.g. the importance of effective positioning of the baby and how feeding drives milk supply.	Thank you.
Association of Breastfeeding Mothers	Guideline	21	18	'how to encourage and support women with common breastfeeding problems' feels like insufficient detail on what is a crucial point. Further bullet points could help inform training. Expectation that staff receive UNICEF Baby Friendly training could be referenced.	Thank you for your comment. It is important to understand that this list was not intended to be exhaustive or particularly detailed. Training and professional competencies as such are outside the remit of this guideline.
Association of Breastfeeding Mothers	Guideline	22	19	This would benefit from a specific reference to where the support may be found AND the need for an option to signpost to more	Thank you for your comment, which the committee discussed. They concluded that it's the responsibility of practitioners to know

				specialist support. It may not be the mother who makes contact (as this wording implies) but the professional making a referral to a peer support team or breastfeeding specialist.	exactly where to refer in any given area and therefore it is not necessary for this recommendation to be any more specific. They therefore did not change this recommendation in the final version of the guideline. However, they decided to add to the recommendation around breastfeeding assessment and specifically about what to do if there are ongoing concerns, that referral to additional support such as lactation consultant or peer support should be considered.
Association of Breastfeeding Mothers	Guideline	23	1	'information about opportunities for peer support' implies there isn't an integration between an infant feeding team and local peer support services when in fact, the integration will be at the heart of breastfeeding support in the community. 'Signposting to peer support as part of an integrated service offering ongoing care' although this needs care as peer support is often key in first 24-48hrs.	Thank you for your comment. We have added a recommendation about providing information to women about available support, both statutory and voluntary before transfer from the maternity unit to community care or before the midwife leaves after a home birth. The particular arrangement of peer support may differ depending on the local area so we have not changed the wording but we appreciate that in many places peer support may be integrated within the routine statutory services.
Association of Breastfeeding Mothers	Guideline	23	014 - 015	Positive to see reference to responsive breastfeeding but this may contradict the next line 'how often babies typically need to feed and for how long'. Historically parent have received confusing messages about counting minutes and scheduling feeds which contradicts the evidence that supports responsive feeding. Could replace with 'that babies vary in how frequently they need and for how long and measuring feeding time may not be the best way to assess intake' or	Thank you for your comment. The committee agree with the point you are making and have responded by amending that particular point, which now reads 'how often babies typically need to feed and for how long, taking into account individual variation'.

				'how often babies typically need to feed and for how long, taking into account there is individual variation'. You could refer to the UNICEF Baby Friendly assessment tools here.	
Association of Breastfeeding Mothers	Guideline	23	26	The reference to fatigue implies that fatigue in new parents is peculiar to breastfeeding which is incorrect. Breastfed parents may in fact receive better quality sleep according to evidence.	Thank you for your comment. The committee agrees that this was potentially misleading. What was meant that fatigue itself is not exclusive to breastfeeding but it may sometimes be more difficult to manage when breastfeeding because breastfeeding is always done by the woman, therefore we have revised the wording to say "strategies to manage fatigue when breastfeeding".
Association of Breastfeeding Mothers	Guideline	23	27	There are times when supplementation may be clinically required so to speak of simple 'disadvantages and advantages' feels unhelpful. Could talk about 'when supplementary feeding may be appropriate and when it may not be required'.	Thank you for your comment. The committee acknowledge your point and have agreed to edit this bullet point to now refer to 'supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated…' It therefore no longer references 'advantages and disadvantages of supplementary feeding'.
Association of Breastfeeding Mothers	Guideline	25	2	I don't feel the wording around formula-feeding is very helpful. We also do not have any reference to donor human milk which is increasingly an option. If a family 'need' to formula feed and know this antenatally, donor milk may be an option in some cases. Perhaps discuss the need to have individually tailored conversations around infant feeding as a replacement for this wording. If a family feel they need to formula feed this is also a time to check compatibility with medication alongside breastfeeding as this is commonly an area of misconceptions.	Thank you for your comment. While finalising the guideline, the committee made several changes to the recommendations about formula feeding. For example, one recommendation now refers to discussions with parents (before and after birth) who are considering or who need to formula feed. That recommendation now also states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. The committee felt that the recommendations around provision

				e.g. refer to Breastfeeding Network drugs in breastmilk service and UKDILAS.	of support for feeding did already reflect the importance of a person centred, tailored approach to conversations and that the edits they made have strengthened this. In relation to your point about medication and breastfeeding the committee also added a reference to 'safe medication use' as a topic for discussion during the provision of information and advice about breastfeeding.
Association of Breastfeeding Mothers	Guideline	25	4	Clarification that these are conversations for the postnatal period	Thank you for your comment. This is not necessarily the case. For women who need to formula feed or who consider formula feeding, these discussions might be relevant to have before feeding is started. Although discussion should absolutely continue and sometimes perhaps get more in depth in the postnatal period.
Association of Breastfeeding Mothers	Guideline	25	18	Great to see reference to responsive bottlefeeding although there are times when this may less clinically appropriate e.g. paced bottlefeeding may not be ideal if a baby needs to gain weight rapidly after a period of faltering growth or has other medical issues.	Thank you for your suggestion, which the committee discussed. They were unable to make changes to this recommendation because the situation you describe would be a special case - clinically speaking - and not therefore covered by the scope of this guideline.
Association of Breastfeeding Mothers	Guideline	26	8	This should include reference to the fact that mixed/ combination feeding is an option and continuing to give some breastmilk is possible alongside giving formula.	Thank you for your comment. The committee agreed with your suggestion and have edited a recommendation in the formula feeding section which now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk.
Baby Sleep Information Source	Evidence Review M	7	17	It is indicated that one of the studies conducted by our team (Ball 2011) compared bed-sharing to side-car crib. This is incorrect.	Thank you for your comment. We have amended the wording around the comparison for Ball 2011 and 2006 as

				The RCT by Ball et al (2011) compared shared sleeping in the form of a side-car crib to no shared sleep surface (stand alone bassinette). The video-based RCT by Ball et al (2006) was a 3-way comparison of bed-sharing, side-car crib, and stand-alone bassinette. A further video study by Ball (2006) examined bed-sharing vs. cot-at-bedside. It is unclear whether the latter study was captured via the literature search as it is published in a human behaviour rather than a clinical journal and is not mentioned among the excluded studies in appendix K. Ball, H. L. (2006). Parent-Infant Bedsharing Behavior: Effects of Feeding Type and Presence of Father. *Human Nature*, *17*(3), 301–318.	suggested. The study by Ball 2006 referenced was not captured in our literature review and does not meet the inclusion criteria for the review as the study doesn't include the pre-defined outcomes set in the protocol.
Baby Sleep Information Source	Evidence Review M	8	6	Table 2: Maternal satisfaction was not the primary outcome measure for Ball et al (2006). The primary outcome measure was mean breastfeed frequency per hour during the overnight video observation in the randomised condition. The result was that mothers and babies allocated to both the bed-sharing and side-car conditions breastfed significantly more frequently than mothers and babies allocated to the stand-alone cot condition.	Thank you for your comment. The purpose of the outcome column in table 2 is to list the outcomes from the studies that met the prioritised outcomes in our protocol, regardless of whether or not they are the primary outcome. The primary outcome of mean breastfeed frequency per hour was not prioritised as an outcome in the protocol, therefore the data on this outcome was not included in our review.
Baby Sleep Information Source	Evidence Review M	11	3	We wish to clarify that Ball 2016 compares often bedsharing versus rarely bedsharing AT HOME DURING FIRST 13 POSTNATAL WEEKS as opposed to side car crib versus standalone cot DURING THE POSTNATAL HOSPITAL STAY in Ball 2011. We consider	Thank you for your comment. We have added the settings as suggested to the clinical evidence table in appendix D for Ball 2016 and Ball 2011.

				it important to acknowledge the different settings.	
Baby Sleep Information Source	Evidence Review M	17	13	We are pleased to see the committee agreed that healthcare professionals should not routinely advise parents against sharing a bed with their baby.	Thank you for your comment.
Baby Sleep Information Source	Evidence Review M	17	35	We are very pleased to see that the committee agreed 'that if healthcare professionals advice parents not to share a bed with their baby, this would most likely lead to less successful or shorter breastfeeding'.	Thank you for your comment.
Baby Sleep Information Source	Evidence Review N	19	45	We are pleased to see clear guidance issued regarding the amount of alcohol that is considered to make bed-sharing unsafe. We are often asked about alcohol and bed-sharing (e.g. timing and amount of alcohol consumption and effect of its awareness of baby during sleep) and have been unable to find any specific data regarding the timing of alcohol consumption relative to bedsharing taking place, so would appreciate learning whether the panel have unearthed anything helpful in this regard.	Thank you for your comment. In the studies that met the inclusion criteria for this review, we did not find any evidence pertinent to timing of alcohol consumption.
Baby Sleep Information Source	Guideline	8	13	Fatigue is mentioned as a topic for discussion during postnatal care of women. Post-partum fatigue can be related to normal aspects of new parenthood and to underlying clinical issues, but is not specifically mentioned in the linked clinical management guide. What guidelines should health professionals refer to in assessing whether postpartum fatigue is indicative of a medical or psychological issue? What advice is given	Thank you for your comment. Evidence on this specific issue was not reviewed by the guideline committee so we have not been able to make more specific recommendations about this.

				to women who are experiencing persistent postpartum fatigue that persists beyond the first 6-8 weeks?	
Baby Sleep Information Source	Guideline	16	2	We are extremely pleased to see the guideline recommends discussion of safe bed-sharing practices with parents in addition to discussion of contraindications to bed-sharing. This is a welcome addition to the guidance and helps to normalise bed-sharing as a common practice in the UK. We hope this will reduce the stigma around bed-sharing and encourage parents to openly and honestly discuss infant sleep safety with health professionals; we also hope this guidance standardises practice such that health professionals will offer non-judgemental information about bed-sharing in all parts of the country, and reduce variation in practice.	Thank you.
Baby Sleep Information Source	Guideline	16	10	We are pleased to see clear guidance issued regarding the amount of alcohol that is considered to make bed-sharing unsafe. We are often asked about alcohol and bed-sharing (e.g. timing and amount of alcohol consumption and effect of its awareness of baby during sleep) and have been unable to find any specific data regarding the timing of alcohol consumption relative to bedsharing taking place, so would appreciate learning whether the panel have unearthed anything helpful in this regard.	Thank you for your comment. Details about timing of alcohol consumptions were not listed as a factor in the review protocol and the committee were therefore unable to comment on this.
Baby Sleep Information Source	Guideline	17	14	Fatigue and sleep deprivation are mentioned as potentially challenging aspects of the postnatal period that may affect bonding and emotional attachment. What guidance,	Thank you for your comment. We did not review evidence on interventions or support in relation to fatigue and sleep deprivation

				support, or intervention should health professionals signpost parents to if they are finding fatigue and sleep deprivation particularly challenging?	and have therefore not provided any detail on this matter.
Baby Sleep Information Source	Guideline	General	General	As the remit of our organisation is parent and infant sleep, we have confined out comments to only those sections of the guideline relating to this topic, specifically fatigue, sleep deprivation, SIDS, co-sleeping, bed-sharing and bedding arrangements on postnatal wards.	Thank you for providing comments on these issues.
Baby Sleep Information Source	Guideline	General	General	We asked the users of the Baby Sleep Info Source website for their comments on the draft guideline so we could convey their views in our response as a registered stakeholder. Only one comment was received which requested that the guidance consider recommending that postnatal wards should make side-car cribs available to all women and babies postnatally. The use of side-car cribs in the immediate postpartum stay has been found to increase the frequency of breastfeeding and maternal satisfaction during the postnatal stay for women experiencing non-medicated vaginal deliveries, and to improve safety for babies and maternal satisfaction following c-section deliveries. Ball, H. L., Ward-Platt, M. P., Heslop, E., Leech, S. J., & Brown, K. A. (2006). Randomised trial of infant sleep location on the postnatal ward. Archives of Disease in Childhood, 91(12), 1005–1010. https://doi.org/10.1136/adc.2006.099416 Tully, K. P., & Ball, H. L. (2012). Postnatal Unit Bassinet Types When Rooming-In after	Thank you for this comment and the suggestion, however, this topic is not covered within the scope of this guideline and was therefore not reviewed or commented on.

				Cesarean Birth: Implications for Breastfeeding and Infant Safety. Journal of Human Lactation, 28, 495–505. https://doi.org/10.1177/0890334412452932	
Beat SCAD	Guideline	9	5	1.2.3 At each postnatal contact by a midwife, assess the woman's physical health, including the following:for all women: Beat SCAD suggests adding “symptoms and signs of Spontaneous Coronary Artery Dissection (SCAD), which can cause myocardial infarction or cardiac arrest in women with few or none of the traditional cardiovascular risk factors associated with atherosclerotic-induced cardiac events”. The lack of awareness of SCAD is a major hinderance to its timely identification, diagnosis and treatment. Beat SCAD are aware of an urgent need to raise awareness among healthcare professionals, including maternity and midwives through talks given at various hospitals and attendance at Maternity and Midwifery Festivals where most delegates had never heard of SCAD. SCAD is now included in the Myles Textbook for Midwives, 17th edition and Beat SCAD feel it is important for SCAD to be included in the relevant NICE guidelines utilised by Maternity and Midwifery professionals.	Thank you for your comment. We have not included this in the recommendation because the guideline is not attempting to provide the detail of a text book and cannot cover all possible scenarios and conditions in detail. We have added a recommendation about listening to the women and responding to their needs. We think that listening to the women's concerns, and making a broad ranging assessment of various aspects of the woman's health (as in this recommendation) would capture conditions such as SCAD.
Beat SCAD	Guideline	10	1	1.2.4 At the first postnatal midwife contact, inform the woman that the following are symptoms or signs of potentially serious conditions, and she should seek medical advice without delay if any of these occur: chest pain, which could indicate venous thromboembolism or cardiac problems Beat	Thank you for your comment. We have not included this in the recommendation because the guideline is not attempting to provide the detail of a text book and cannot cover all possible scenarios and conditions in detail. We have added a recommendation about listening to the women and responding

				SCAD suggests including information regarding myocardial infarction caused by Spontaneous Coronary Artery Dissection (SCAD) within this section. A problem with assessing chest pain in terms of potentially being cardiac in nature leads to an expectation of traditional cardiovascular risk factors being present such as hypertension, obesity, diabetes etc. However, research to date indicates that SCAD patients have fewer traditional cardiovascular risk factors than patients with atherosclerotic coronary artery disease, and some have no risk factors at all. SCAD patients who do present with traditional cardiovascular risk factors tend to be older, in keeping with the wider population, and therefore less likely to be the pregnancy associated cases. It is also important to emphasise that chest pain is not always the main symptom and may not be present at all. The pain may be prevalent across the back, neck, jaw and/or arm(s). These could easily be symptoms of something else, less severe, but in order to save lives a high suspicion of SCAD is required and should be investigated.	to their needs. We think that listening to the women's concerns, and making a broad ranging assessment of various aspects of the woman's health would capture conditions such as SCAD.
Beat SCAD	Guideline	General	General	*Guideline CG37 covers the routine postnatal care women and their babies should receive for 6–8 weeks after the birth. It includes advice given on breastfeeding, and the management of common and serious health problems in women and their babies after the birth. Beat SCAD would like to suggest that a specific reference to Spontaneous Coronary Artery Dissection (SCAD) be included in*	Thank you for your comment. The committee acknowledges SCAD and discussed whether to include it in the guideline. It was agreed that because the guideline is not attempting to provide the detail of a text book and cannot cover all possible scenarios and conditions in detail this was not specifically mentioned. A recommendation about listening to the women and responding to

				relation to serious health problems in women postpartum. SCAD is not common but it can have devastating consequences, particularly when it happens in association with pregnancy, and the lack of awareness is a major hinderance to its timely identification, diagnosis and treatment. In most contemporary patient series, pregnancy-associated cases account for approximately 10% of cases of SCAD. However, 21–27% of myocardial infarctions in pregnancy and 50% of post-partum coronary events are reportedly due to SCAD. SCAD may occur at any time during or after pregnancy. Cases have been reported from the 5th week of pregnancy through to very late post-partum (12-24 months), where these later onset cases may be in association with breastfeeding. Most cases (>70%) occur post-partum and most commonly within the first week. Beat SCAD therefore considers that guideline CG37 should be updated with SCAD information to ensure it is being considered when potential symptoms arise during the 6-8 weeks after birth. Factors which have been identified as suggesting an increased risk for SCAD include multi-parity, fertility hormones and pre-eclampsia, so it is essential that these aspects of a woman's history are considered with respect to potential SCAD/myocardial infarction symptoms. Studies have suggested that pregnancy- associated SCAD presentations can be more severe than SCAD outside of pregnancy, they are more likely to involve	their needs has been added and we think that listening to the women's concerns, and making a broad ranging assessment of various aspects of the woman's health would capture conditions such as SCAD.

				the main coronary arteries and/or multivessel dissections, and are more likely to result in greater damage to the heart causing ejection fraction reduction leading to longer term health consequences. References: Adlam D, Alfonso F, Maas A, Vrints C; Writing Committee. European Society of Cardiology, acute cardiovascular care association, SCAD study group: a position paper on spontaneous coronary artery dissection. Eur Heart J. 2018 Feb 22. doi: 10.1093/eurheartj/ehy080. Hayes SN, Kim ESH, Saw J, Adlam D, Arslanian-Engoren C, Economy KE, Ganesh SK, Gulati R, Lindsay ME, Mieres JH, Naderi S, Shah S, Thaler DE, Tweet MS, Wood MJ; American Heart Association Council on Peripheral Vascular Disease; Council on Clinical Cardiology; Council on Cardiovascular and Stroke Nursing; Council on Genomic and Precision Medicine; and Stroke Council. Spontaneous Coronary Artery Dissection: Current State of the Science: A Scientific Statement From the American Heart Association. Circulation. 2018 May 8;137(19):e523-e557. doi: 10.1161/CIR.0000000000000564. Epub 2018 Feb 22. Review. Hayes SN, Tweet MS, Adlam D, Kim ESH, Gulati R, Price JE, and Rose CH; Spontaneous Coronary Artery Dissection: JACC State-Of-The-Art Review. https://www.jacc.org/doi/full/10.1016/j.jacc.2020.05.084 J Am Coll Cardiol. 2020 Aug, 76 (8) 961-984	

Postnatal Care

Consultation on draft guideline - Stakeholder comments table
16/10/2020 – 25/11/2020

Betsi Cadwaladr University Health Board	Evidence Review K	26	010 - 017	Lactation Suppression- This is poorly covered in HCP education and requires greater attention. The self help measures needs to include applying warmth to gain symptomatic relief	Thank you for your comment. Self-help measures during lactation suppression are covered by the recommendation, however, the list includes examples and is not exhaustive. Your suggestion may be valid but was not prioritised by the committee in this list.
Betsi Cadwaladr University Health Board	Evidence Review N	16	10	Bed sharing - Have had ≤2 units of alcohol – Service would disagree with this & would urge NICE to reconsider. Any amount of alcohol is potentially sedating & would pose a danger for bed sharing. There is a feeling that this muddies the waters and allows for misinterpretation (does everyone know what a unit looks like? Etc)	Thank you for your comment. This element of the recommendation was based on the evidence included in the review and supported by committee expertise. There was no evidence that parents should be advised not to share a bed with their baby if any alcohol at all had been consumed. Having discussed your comment and reflected again on the evidence, the committee therefore made no change to this recommendation.
Betsi Cadwaladr University Health Board	General	General	General	Breast milk production- Please consider using the correct physiological term – Lactation	Thank you for your comment. Breast milk production is a commonly used and easily understandable term so we do not see a problem using it.
Betsi Cadwaladr University Health Board	General	General	General	Women's services have stated that regarding the evidence pertaining to midwifery they have no comments to offer, as the listed evidence is appropriate Neonatal services have reviewed the evidence and have no comments to offer as the listed evidence is appropriate Initial overall comment – It would be good to know if a Lactation Specialist has been included in the NICE review	Thank you for your comment. An infant feeding specialist who is also a lactation consultant was part of the guideline committee.
Betsi Cadwaladr University Health Board	Guideline	4	13	Observe at least 1 effective feed- It would be useful to have objective criteria for what is meant by "effective" eg using the UNICEF BFI BF assessment tool	Thank you for your comment. We have now added a definition of 'effective feed' to the 'Terms used in this guideline' section and a

					direct link to this definition within the recommendation.
Betsi Cadwaladr University Health Board	Guideline	14	28	1.3 States " Provide lactation/feeding support to BF mothers whose baby is visibly jaundiced" but crucially NICE does not give benchmarks for what that care & support should look like This means there is huge variability in the actual care provided – this needs to state clearly that a Infant feeding specialist may need to be consulted to inform the care plan. Locally we have a standard lactation/BF support care plan for when baby is jaundiced to inform the care provided by staff	Thank you for your comment. This refers to another guideline and is thus outside the remit of this guideline.
Betsi Cadwaladr University Health Board	Guideline	15	001 - 002	– Needs to require that mother & baby are reviewed by an infant feeding specialist to inform the BF/lactation support plan -as well as a medical practitioner – so many of these babies end up not being breastfed as a consequence of poor breastfeeding & lactation care to the mother	Thank you for your comment. Issues around faltering growth are covered by another NICE guideline. However, the recommendations in the postnatal care guideline has an extensive section on breastfeeding support and we have now added that if there are ongoing concerns referral to additional support such as lactation consultant or peer support should be considered.
Betsi Cadwaladr University Health Board	Guideline	15	10	NICE needs to address the huge service inequity in Infant feeding/lactation/breastfeeding in the UK. We need service level agreements as regards benchmarked standards for education & what an infant feeding service should look like Locally we have introduced a benchmarked education pathway Basic levels of training for all HCPs (UNICEF BFI)E Entry level "Informed Level of	Thank you for your comment. This is outside the remit of this guideline, the guideline scope states that competencies of healthcare professionals involved in postnatal care will not be covered by this guideline. We have however included some basic knowledge in relation to breastfeeding and lactation that would be expected from healthcare professionals providing postnatal care.

				lactation/Breastfeeding education “Skilled” Level of lactation/Breastfeeding education “Specialist” Level of lactation/Breastfeeding education	
Birth Companions	Comment form question 1	N/A	N/A	Q. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. A. Improved postnatal support for women separated from their babies – whether it be temporarily or permanently – would make a hugely significant contribution to breaking cycles of disadvantage for mothers and children. Current provision in this area is incredibly low, and yet the impact of removal is high in terms of mental health, engagement with wider support services, and attitudes to risk. The MBRRACE reports on maternal deaths repeatedly show that 20% of the women who die in pregnancy and the year after birth are known to social services – a figure that has increased from 12% in 2012-14 - and that suicide is the leading cause of death up to 12 months after birth. https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf Implementation of changes in this area will require a shift in attitudes, a greater	Thank you for your comment. We recognise the importance of highlighting this relatively small but potentially 'at risk' group of women. This guideline applies to women who have been separated from their babies and the recommendations aim to highlight the importance of capturing emotional, psychological and social issues and related concerns that the woman, her partner or healthcare professional might have. This may include need for multiagency working and clear communication between healthcare professionals as well. We have highlighted in the section "Communication between healthcare professionals". We have not specified this particular group of women who have been separated from their babies as there are many different circumstances where mental health concerns might arise. Postnatal mental health issues are more thoroughly covered by the NICE guideline on antenatal and postnatal mental health which we have referred to, and we have also referred to the NICE guideline on pregnancy and complex social factors which, as the title says, covers pregnancy, however, many of the principles can be applied to the postnatal period as well.

				commitment to universally trauma-informed and trauma-responsive care models, and enhanced multi-agency working across maternity and social care systems.	
Birth Companions	Comment form question 4	N/A	N/A	*Q. 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. A. It is vital that any reduction to in-person postnatal contacts on the grounds of infection risk are proportionate, justified, time-limited, and transparently communicated Working with women facing multiple disadvantage during the pandemic we have noted that across our caseload women are experiencing reduced contacts across all service areas, increased isolation, worsening mental health including pronounced risk of self-harm and suicide, and an overall heightened fragility of circumstances including financial hardship, vulnerable housing situations, domestic abuse and substance misuse.*	Thank you for your comment. The guideline is aiming to be relevant in the longer term and not be specific to the conditions imposed by the Covid-19 pandemic. However, we have considered some of the anecdotal lessons learnt during the pandemic in relation to, for example, increased use of remote contacts, with both disadvantages and some advantages. The guideline does not specify the nature of every contact but specifies that the first midwife visit and the health visitor home visits should be face to face (i.e. in person). The guideline also says that information provision postnatally should be provided in face to face discussions and supplemented by virtual discussion or written materials. The evidence the committee reviewed before the pandemic showed that women value face-to-face support (particularly in relation to breastfeeding) and remote contacts were considered potentially beneficial in addition to face to face contacts but not replacing them.
Birth Companions	Guideline	5	3	Considerations around the timing of transfer to home care should include reference to transfers to other settings including parenting assessment units, community or prison-based Mother and Baby Units, or to prison without the baby. This should also include specific reference to transfer home after	Thank you for your comment. Specialist care as such is outside the scope of this guideline, however, routine postnatal care for women who do not go 'home' is covered. We have changed the wording to say 'transfer to community care' rather than 'home care'. The recommendations aim to highlight the

				separation from a baby after birth, to address the complex needs of women whose children are removed by social services.	importance of capturing emotional, psychological and social issues and related concerns that the woman, her partner or healthcare professional might have. We have not specified particular groups of women, such as those who have been separated from their babies, as there are many different circumstances where concerns and additional support might arise. We have referred to the NICE guideline on pregnancy and complex social factors which, as the title says, covers pregnancy, however, many of the principles can be applied to the postnatal period as well.
Birth Companions	Guideline	7	2	Add 'or voluntary sector agency' after friend in the sources of support	Thank you for your comment. We have revised the wording here and added a definition of what we mean by 'partner' in the context of this guideline, in some cases this might be someone from a voluntary sector organisation. We have also added to another recommendation about providing information about available support including voluntary sector services.
Birth Companions	Guideline	7	8	Add 'trauma-informed' to the list of bullet points here	Thank you for your comment. We appreciate the importance of trauma-informed care but have not included this in this recommendation. We think taking into account the needs and preferences of the woman, being sensitive, individualised and respectful covers this sufficiently.
Birth Companions	Guideline	7	14	Add 'appropriate' – so this reads 'translated by an appropriate interpreter' – this is due to reports of reliance on partners, children, or known individuals from a woman's	Thank you for your comment. We have revised this to say "appropriate translator" as suggested.

				church or local community being relied on to interpret sensitive information – see our research with Birthrights for more information https://hubble-live-assets.s3.amazonaws.com/birth-companions/attachment/file/91/Holding_it_all_together_-_Exec_Summary_FINAL___Action_Plan.pdf	
Birth Companions	Guideline	7	23	We would strongly encourage a broader range of factors are considered in this list, beyond those in CG110 – as specified in https://hubble-live-assets.s3.amazonaws.com/birth-companions/attachment/file/91/Holding_it_all_together_-_Exec_Summary_FINAL___Action_Plan.pdf Including the following factors will be particularly important given the increased fragility of many families' lives due to COVID-19: - known to social services- homeless/ vulnerably housed - mental health needs - financial hardship/ poverty - women in contact with the criminal justice system - women with a history of sexual abuse - women with experience of sex work	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The groups listed in your comment may well also be relevant, however, these are not covered by the above NICE guideline.
Birth Companions	Guideline	8	21	Add 'discuss contact with other agencies such as police, probation, substance misuse services, immigration and social services' to reflect the importance of multi-agency working and shared safeguarding responses	Thank you for your comment. The committee discussed your suggestion but they felt your point was already addressed by referencing the NICE guideline on domestic violence and abuse where the same advice would be found.

				where women are experiencing multiple disadvantage	
Birth Companions	Guideline	17	16	Add the need for signposting to specialist services able to help support women and families in developing these vital relationships	Thank you for your suggestion. The committee agreed not to make this amendment because in practice referrals stemming from concerns over emotional attachment would not be made within the first 8 weeks following birth.
Birth Companions	Guideline	17	16	Important to specify that parents' concerns and queries are listened and responded to, ensuring they feel heard and understood	Thank you for your comment. The committee agrees and this is a more general issue and we have added a recommendation about listening to the women and responding to their needs and preferences. In relation to the care and assessment of the baby, we have now specified in the recommendation that parents should be asked about any concerns.
Birth Companions	Guideline	17	19	Additional, specialist support on bonding and attachment will be also necessary where women are at risk of infant removal, or have experienced infant removal, as well as for those with personal experience of the care system as children	Thank you for your suggestion, which the committee discussed. They agreed to add the experience of birth trauma as one of the circumstances in which some parents may need additional support in bonding and emotional attachment.
Birth Companions	Guideline	17	21	Expand 'complex social needs' to include the full list of factors referenced above including housing issues, financial hardship, substance misuse, domestic abuse, contact with the criminal justice system, social services or immigration systems	Thank you for your comment. We did not think it is necessary to list different kinds of potentially complex social needs. We have revised this to say 'complex psychosocial needs'.
Birth Companions	Guideline	17	21	Add mental health issues to this list	Thank you for your comment. We have revised this to say complex psychosocial needs.

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Birth Companions	Guideline	23	8	In addition, offer non-judgmental, evidence-based information to mothers who are considering breastfeeding, or who elect to breastfeed alongside the use of prescribed drug-replacement therapies and medications including methadone and subutex	Thank you for your comment. We do not disagree with the comment but we have not covered these groups specifically in this guideline and think that generally the principles of discussion and support related to infant feeding applies to them too.
Birth Companions	Guideline	23	8	Add reference to specialist breastfeeding support for women with HIV	Thank you for your comment. Specialist care (care beyond routine postnatal care) needed by women with pre-existing conditions is not covered by the scope of the guideline.
Birth Companions	Guideline	23	8	An additional point should be added here to highlight other barriers to accessing BF support including language/literacy barriers, poverty, cultural/social barriers/ and breastfeeding against expectations	Thank you for your comment. The committee agrees that there may be many barriers for breastfeeding support which we have tried to minimise through the recommendations. Language barriers have been covered by the recommendation under 'Principles of care' which talk about tailoring information provision, including using translators when needed. Poverty is covered in the recommendation you're commenting on which states, based on evidence which was reviewed, that women from low income or disadvantaged background may need additional support. In the section on 'Role of the healthcare professionals supporting breastfeeding' we also state for example that healthcare professionals should be respectful of the woman's cultural influences and preferences.
Birth Companions	Guideline	25	16	Add ‘signpost families to local services able to support those on a low-income with accessing formula on an ongoing, reliable basis’	Thank you for your suggestion. The committee did not make this change to the recommendation because they are aware that formula milk can be obtained for people on low incomes via Healthy Start vouchers,

					which health visitors can sign for - so there would not be a need for signposting.
Birth Companions	Guideline	26	13	Add 'if the baby is separated from the mother' before 'or in the event of the death of the baby'	Thank you for your suggestion. The committee did not make this change to the recommendation because they believe it is already covered by the wording '…if breastfeeding is not started or is stopped.'
Birth Companions	Guideline	29	1	Further suggested recommendations for research We would urge NICE to consider including an additional recommendation for further research into either: the postnatal care of women who have been separated from their baby or are preparing to separate from their baby, or the postnatal care of women known to social services. We suggest this is in direct response to the evidence provided by MBRRACE of an increasing number of maternal deaths among women known to social services, and widespread recognition of the limited postnatal support offered to women who have experienced removal. Research by the Nuffield Family Justice Observatory showed newborn care proceedings have doubled in recent years - https://hubble-live-assets.s3.amazonaws.com/birth-companions/attachment/file/229/Born_into_care_Newborns_in_care_proceedings_in_England.pdf	Thank you for your comment. We agree that these women are an important population. However, these research recommendations are outside the scope of the guideline.

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Birth Trauma Association	Guideline	4	1	The guideline needs to recognise that parents are legally autonomous. The statement “People have the right to be involved in discussions and make informed decisions about their care” should be changed to read: “People have the right to be given the information that they need to make informed decisions about their care, and to have those decisions respected”.	Thank you for your comment. This is a standard text used by NICE and we have passed your comment to NICE.
Birth Trauma Association	Guideline	4	5	This guideline needs to recognise that some women give birth at home, and therefore specify what checks should be offered by a midwife before she leaves. It i	Thank you for your comment. The committee agrees and have changed the wording in this section to reflect this, the checks before transfer from the maternity unit and after home birth before the midwife leaves should be the same.
Birth Trauma Association	Guideline	4	5	The guideline should state that the different checks (bladder function etc.) should be offered to the woman, recognising that the woman has the option to refuse them.	Thank you for your comment. The option of refusing care applies to all care given and is not specific to this section, we have therefore not changed the wording.
Birth Trauma Association	Guideline	4	6	The check on the woman’s health before discharge should include offering to check stitches.	Thank you for your comment. The recommendation in this section does not list all the various aspects of woman's health that should be assessed, instead it refers to recommendations about the assessment of the woman's health which cover various aspects including perineal healing and wound healing.
Birth Trauma Association	Guideline	5	9	There should be greater flexibility in home visits from midwives and health visitors. Women report having to stay in all day for appointments, or appointments being scheduled when they have visitors which can make it difficult for them to disclose any difficulties they are having.	Thank you for your comment. The specific arrangements for exact timings for the visits is something that needs to be organised locally.

Birth Trauma Association	Guideline	6	2	The guideline should include recommendations about what information women should be given before discharge, or before the midwife leaves in the case of a homebirth, so that they are aware of signs of serious problems which might develop before the midwife's first visit, and who the parents should contact if they notice these signs.	Thank you for your comment. We have added a recommendation about providing information about what to expect, what support is available and who to contact if there are concerns before transfer to community care or before the departure of the midwife after home birth.
Birth Trauma Association	Guideline	7	007 - 011	We recommend opening this section with the statement: "Women should be listened to and recognised as experts in their own physical and mental health."	Thank you for your comment. The committee agrees about the importance of listening to the women and being responsive to their needs and preferences and have added a recommendation about this. This was also recently highlighted by the Ockenden report.
Birth Trauma Association	Guideline	9	005 - 015	We recommend that women should be asked about pelvic floor, urinary and anal dysfunction, and referred to a women's health physiotherapist or urogynaecologist if appropriate. If they have had a caesarean, they should also be asked about abdominal wound pain.	Thank you for your comment. These issues have been covered in the guideline: recommendations include asking about and assessing bladder and bowel function and perineal health and we have also added a recommendation about providing information about pelvic floor exercises and when to seek help. The recommendations also cover referral to specialist services where needed and specific mention of referral to physiotherapy has been added. The recommendations also include about assessing wound healing in relation to caesarean birth.
Birth Trauma Association	Guideline	10	6	As well as giving women the opportunity to talk about their birth, it would be useful to include a line stating that women should be informed about birth debriefing services where they can talk about their birth with a midwife or doctor. If a woman is showing	Thank you for your comment. The committee discussed your suggestion and agreed to edit the recommendation to say that the woman should be given information about relevant support and birth reflection services, if appropriate. In addition they cross

				signs of post-traumatic stress disorder, health visitors should inform them of the opportunity for referral to appropriate therapy.	referenced from this recommendation to the NICE guideline on antenatal and postnatal mental health, specifically the section on traumatic birth, stillbirth and miscarriage and the NICE guideline on post-traumatic stress disorder.
Birth Trauma Association	Guideline	10	6	One in 25 women experience postnatal PTSD, so we recommend PTSD screening be carried out on all women using the City Birth Trauma Scale. Access to treatment for PTSD should be available in a timely manner to all women who require it.	Thank you for your comment. We have added a reference to the NICE guideline on antenatal and postnatal mental health which has a section on birth trauma and the NICE guideline on PTSD.
Birth Trauma Association	Guideline	10	006 - 008	Women should be routinely advised on the complaints process.	Thank you for your comment. The NICE guideline on Patient experience in adult NHS services, which we refer to in the guideline, already covers the issue about complaints processes and giving feedback about their care (see recommendations 1.3.12 and 1.3.13 in CG138).
Birth Trauma Association	Guideline	16	003 - 004	1.3.12 add “rather than face down or on their side” in line with guidance from The Lullaby Trust	Thank you for your comment. We have added "or on their side" to the recommendation.
Birth Trauma Association	Guideline	16	6	1.3.12 Add recommendation not to use sleep positioners, in line with guidance from The Lullaby Trust	Thank you for your comment. We did not think this addition was necessary in relating to advice on safer bed sharing, it was not identified in the evidence review. We have added a mention of established safer sleeping guidance to a recommendation about providing information to parents about caring for their baby. In the rationale and impact section we provide some examples of sources for this guidance, including the Lullaby Trust.

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Birth Trauma Association	Guideline	16	10	1.3.13 should read “have drunk alcohol”, in line with guidance from The Lullaby Trust	Thank you for your comment. We are not reproducing guidance by the Lullaby Trust and the 2 units of alcohol is based on the evidence reviewed (see evidence review N).
Birth Trauma Association	Guideline	16	13	1.3.13 add the following, in line with guidance from The Lullaby Trust: extreme tiredness premature - 37 weeks or less low birth weight - 2.5kgs	Thank you for your comment. We have added low birth weight to the recommendation as suggested because it is a well-known risk factor, however, preterm babies were outside the scope of this guideline and therefore has not been mentioned in the recommendation. We have clarified this in the rationale and impact section. Extreme tiredness was not something that we reviewed evidence on and therefore cannot comment.
Birth Trauma Association	Guideline	21	13	Mi Midwives and health visitors should be well-informed about which medications (particularly anti-depressants) can safely be taken by breastfeeding mothers. T Midwives and health visitors should be well-informed about normal breastfeeding issues, such as cluster feeding and tongue tie. Treatment and support should be available for mothers experiencing these issues. · Anxiety relating to breastfeeding should not always be seen as sign of postnatal mental health difficulties. Often it is related to a lack of support and advice for breastfeeding mothers.	Thank you this comment. The committee agreed to edit this recommendation, which now makes reference to safe medicine use and prescribing for breastfeeding women. It is important to understand that this list was not intended to be exhaustive or particularly detailed, therefore, not all the issues you mention have been mentioned in the recommendation. Instead the recommendation gives some pointers to basic knowledge that healthcare professionals caring for women and babies in the postnatal period would be expected to have. The committee agrees about your last point and think that the recommendations do already capture the importance of offering appropriate support for breastfeeding.
Birth Trauma Association	Guideline	25	004 - 011	We recommend this section include discussion of combination feeding as an alternative to either exclusive breastfeeding	Thank you for your comment. We have added a statement about this into the first recommendation of this section.

				or exclusive formula feeding, to enable women to understand the full range of feeding options available to them.	
Birth Trauma Association	Guideline	General	General	Partners should be asked about their mental health following traumatic birth. It is recognised that PTSD can be triggered by witnessing a traumatic event, and there is research evidence to shows that some partners who have witnessed traumatic birth develop PTSD as a result.	Thank you for your comment. The scope for this guideline describes the focus as being women and babies from birth to 8 weeks, which explains why the committee recommended that the woman, rather than the father or partner, is given the opportunity to talk about her birth experience. That said, in finalising the guideline, the committee did add to this recommendation by cross referring to the NICE guideline on antenatal and postnatal health, in particular the section on 'traumatic birth, still birth and miscarriage', which recommends that the effect of the birth or miscarriage on the partner should be taken into account.
Birth Trauma Association	Guideline	General	General	There should be guidance on providing support for mothers of premature babies, as having a premature baby can have an impact on a mother's mental health. Although prematurity is addressed in guideline NG25 Preterm labour and birth, it includes very little about the care of the mother.	Thank you for your comment. Preterm babies and specialist care is outside the scope of this guideline and have therefore not been addressed.
Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	5	007 - 021	The language around attachment and bonding is good but it would be helpful to include the idea of parent / carer and infant interaction and relationship.	Thank you for your comment. The definition of emotional attachment and the terms used in this guideline have been revised to capture these issues.
Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	5	25	Studies included if they were initiated within the first 8 weeks, or antenatal period and continued into post natal period. Does this exclude a number of relevant interventions that are aimed at improving attachment but are initiated after this period but still relevant	Thank you for your comment. The scope of the guideline covers postnatal care up to 8 weeks after birth, therefore we are restricted to include studies looking at interventions initiated within this timeframe.

				to this age group of infants 0-8 weeks old. There are a core of relationship capacities parents use with infants that are broadly the same whether used with an 8 week old infant or a 12 month old infant. If this had been broadened more studies might have been included in the review, for example Circle of Security and Minding the Baby.	
Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	12	012 - 015	The guidance mentions that attachment can only be reliably measured in infants 12-18 months of age. However it can be reliably measured by the Infant care Index in infants 0-to 18mths. Infant Care Index Crittenden, P.	Thank you for your comment. The definition of emotional attachment in the review was based on Bowlby's model of attachment theory and internal working models, where it is not possible to assess patterns of attachment in infants until late in the first year. The Infant CARE-Index (ICI, Crittenden, 1981) is the simplest and most versatile of the Dynamic-Maturational Model (DMM) assessments. It assesses patterns of interaction of infants and their carers from birth to about 15 months of age based on a 3-minute video-recorded play interaction. It does not assess attachment & captures the best of dyad's functioning (rather than capturing the dyad's response to stress, i.e., attachment). The care index is a screening tool which assesses affective sensitivity not attachment in itself.
Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	12	012 - 024	Outcomes used were mothers feelings toward babies at 12-18 months of age. There is substantial evidence that infants as young as 8 weeks old already have developed patterns of attachment that can be reliably assessed (P. Crittenden Infant Care Index (ICI) 1981) Interventions that measure the impact of attachment and bonding could be	Thank you for your comment. The definition of emotional attachment in the review was based on Bowlby's model of attachment theory and internal working models, where it is not possible to assess patterns of attachment in infants until late in the first year. The Infant CARE-Index (ICI, Crittenden, 1981) is the simplest and most

				assessed at a much earlier stage and as young as 8 weeks.	versatile of the Dynamic-Maturational Model (DMM) assessments. It assesses patterns of interaction of infants and their carers from birth to about 15 months of age based on a 3-minute video-recorded play interaction. It does not assess attachment & captures the best of dyad's functioning (rather than capturing the dyad's response to stress, i.e., attachment). The care index is a screening tool which assesses affective sensitivity not attachment in itself. ********In addition, outcomes were not only limited to "mother's feelings towards the baby". The critical outcomes set out in the protocol for this review were:****1. Mother's feelings towards the baby when the baby is 12 to 18 months of age****2. Quality of mother-infant interaction when the baby is 12 to 18 months of age****3. Proportion of babies displaying an insecure attachment type (which includes ambivalent, avoidance, disorganised) when the baby is 12 to 18 months of age
Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	13	019 - 023	The guidance is focused on attachment and bonding. Would be helpful to have a focus on the relationship between babies and parents/carers. Incorporating the principles of attunement as a basic tool for all practitioners and the knowledge of the six baby states for engagement.	Thank you for your comment. Attunement was considered too specific and beyond the remit of this guideline. However, interventions meeting the inclusion criteria in the evidence review did include practices in line with attunement: talking to the baby; being responsive to cues or small signals the baby may send; copying the baby's noises and gestures; and providing comfort when the baby is upset.****

Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	13	039 - 041	Lasting change in attachment relationship comes from caregivers developing specific relationship capacities. It would be useful to include more detailed tips for parents/carers to help develop their interaction capacities with their tiny babies. For example, Tune in to your child's cues and interests, talk more describe the world around them, take turns and be a conversational partner, turn off background TV, and ensuring that parents have knowledge of the six baby states for engagement.	Thank you for your comment. We acknowledge that it would be useful for parents/carers to have guidance to develop interaction with their babies. However, guidance of this level is outside the remit of this evidence review.
Blackpool Better Start and NSPCC Baby Steps National Team	Evidence Review O	13	043 - 048	More specific mention of fathers.	Thank you for your comment. We acknowledge that there are other sources of attachment for babies other than the mother e.g. father, mother's partner, other family members. However, the committee agreed to focus the review protocol to mother and baby attachment, thus only studies pertaining to this relationship are included in the review. That being said, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Blackpool Better Start and NSPCC Baby Steps National Team	Guideline	17	002 - 021	The inclusion by NICE of emotional attachment information for universal guidance is welcome. It is interesting to note an overview of several studies and programmes that aim to improve attachment concluded that none provide sufficient evidence to be included in the recommendations. Blackpool Better Start undertook a similar literature review to find an infant attachment tool suitable for universal use as part of the Enhanced Health	Thank you for your comment. Assessment of parent-infant relationship is not covered by the scope of this guideline and we did not look for evidence on the topic, however, we are interested to hear that your review found no evidence on this. Thank you for sharing these examples of interventions, we think that our evidence review would have captured studies relating to these interventions if they otherwise met the inclusion criteria set in the review protocol

				Visitor Programme, unfortunately none matched our requirements. The guidance fails to recognise the importance of professional observation and assessment of parent-infant interactions and relationships. Blackpool Better Start has implemented a suite of evidence-based programmes for parents in the perinatal period which demonstrate that professional intervention can improve the quality of relationships. Our universal programmes have been designed specifically to offer support for parental and parent-infant relationships, which will affect attachment and promote infant social and emotional development. Interventions A town-wide training schedule promoting parent-infant responsiveness and infant brain development through the Harvard Frameworks model and facilitation of the Brain Story certification. Trauma-Informed Care strategy Universal Baby Steps antenatal groups which focus on whole family relationships with the infant pre and post birth Enhanced Universal Health Visiting Service includes Ante-natal visit discussing infant brain development, baby states and promotion of parental responsiveness extra early infancy visits (10-14 days, 3-5 weeks, 6-8 weeks) where parent-infant relationships are observed and discussed improved Perinatal Mental Health screening, the Behavioural Activation programme for perinatal illness and Adverse Childhood Experiences routine antenatal enquiry for early identification of barriers to attachment	(Appendix A, evidence review O) although without detailed references we cannot tell for sure.

				Newborn Behavioural Observation and targeted Newborn Behavioural Assessment which are undertaken with parents to focus on the individual infant's capabilities and implications for care-giving The Solihull Approach which helps parents understand and respond to their infant's cues through a reciprocal relationship Additional Family Nurse Partnership provision offering targeted care to families who meet referral criteria which might suggest risk of poor attachment. Assessment, support and coaching in parent-infant relationship Targeted Video Interaction Guidance Programme, through the use of video, helping parents to recognise positive interactions with their baby allowing them to increase.	
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Evidence Review A	General	General	Suggestion for Research recommendation - No qualitative evidence was reviewed. The mental health outcomes are 'hard' ie. questionnaires at 6-12 weeks and qualitative information could illuminate best practice in this area.	Thank you for your comment. Research recommendations are made when insufficient evidence is found in the evidence review. Evidence review A was a quantitative review, therefore we are unable to write research recommendations for qualitative studies as this evidence base wasn't assessed. It was agreed that evidence review A would be a quantitative review as this evidence was deemed best to address the question at hand.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Evidence Review B	011 012	045 010	"Care needs to be taken on asking women to recount their birth story." For some women with traumatic births this may impede natural processing. This is not mentioned in the discussion. Further comment on intervention for birth trauma is made in point 3 below. Theme 1: Women's general Well-being. Sub-	Thank you for your comment. The evidence review addresses what information women would like to be communicated between healthcare professionals at transfer of care from birth care team to the community care team. Interventions for birth trauma were not included in the protocol for this review

				theme 1.1 Mental health. Only 5 studies were found? There is a body of research in the mental health domain around women's barriers to mental health care that documents how lack of appropriate referral and poor transfer of information from one service to another is related to poor uptake of needed and wanted mental health support. Reilly, N., Kingston, D., Loxton, D., Talcevska, K., & Austin, M. P. (2020). A narrative review of studies addressing the clinical effectiveness of perinatal depression screening programs. Women and Birth, 33(1), 51-59. Smith, M. S., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. BMJ open, 9(1). Buist, A., O'Mahen, H., & Rooney, R. (2015). Acceptability, attitudes, and overcoming stigma. Identifying perinatal depression and anxiety: evidence-based practice in screening, psychosocial assessment, and management. 1st ed. Wiley: Chichester, 51-62. Milgrom, J., & Gemmill, A. W. (Eds.). (2015). Identifying perinatal depression and anxiety: Evidence-based practice in screening, psychosocial assessment and management. John Wiley & Sons.	question and so are not addressed in this review. The references provided were not captured in our literature review. None of the references meet the inclusion criteria for this review; 3 of the references (Reilly 2020, Buist 2015, and Milgrom 2015) are not qualitative studies; and 1 study (Smith 2019) examines the barriers to accessing mental health services and doesn't address the views and experiences about information shared between birth care and community care team
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Evidence Review F	12	40	"Women should be given the opportunity to talk about their birth experience in the first postnatal contact". If the woman perceives their birth to have been traumatic, listen and reflect nonjudgmentally if she wishes to	Thank you for your comment. The text to which you refer is actually some of the data extracted from the included guidelines within that evidence review. These were discussed by the committee and considered as a basis

				discuss her experience. If her feelings persist beyond 4 weeks, she should be signposted to services providing evidence-based interventions for traumatic birth by competent, trained and supervised perinatal-specialist practitioners. (Clearer guidance on this and research recommendation needed? Consider proscription against non-evidence based practice. (This has recently been a problem with wide-spread implementation of a non-evidence based intervention frequently administered by unsupervised practitioners with repeated reports of harm emerging from the application of the intervention). Thus, it is critical to ensure that women who need intervention receive evidence-based interventions administered by competent practitioners. Cross reference NICE CG 192	for making recommendations. The committee did not use these statements verbatim in the guideline and instead made a recommendation that the woman should be given the opportunity to talk about her birth experience and that if it is appropriate then information about relevant support services should be provided. The committee also made a recommendation that at each postnatal contact, the woman's psychological and emotional wellbeing should be assessed. In doing so the recommendations in the NICE guideline on antenatal and postnatal mental should be followed (CG192). The recommendation also states that further assessment and follow up should be arranged if there are concerns. The committee discussed whether to also sign post to CG192 from the recommendation about giving the woman the opportunity to discuss her birth experience and agreed that in the final version of the guideline, there should be a link to the specific section of CG192 about traumatic birth, still birth and miscarriage.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Evidence Review H	36	Table 9	Research recommendation. Bullet point “depression” – suggested as an outcome. We suggest adding “Anxiety” and PTSD to this to reflect the broader range of problems women may suffer from in the perinatal period.	Thank you for your comment. We have added anxiety and PTSD to the outcomes as suggested.
British Association of Behavioural and Cognitive	Evidence Review O	12	043 - 048	“The committee also discussed how it can be important for the woman’s partner (or whoever supports her) to also be aware of the importance of emotional attachment so	Thank you for your comment. We acknowledge that there are other sources of attachment for babies other than the mother e.g. father, mother's partner, other family

Psychotherapies (BABCP)				that they can support the woman, including by helping with other tasks that would otherwise prevent the woman for spending this time with her baby for example by offering to help with domestic chores or other childcare demands. “As written, this statement implies that the mother is the primary source of bonding/attachment and other carers/partners and family members are there to support the mother in practical ways so that she can focus on developing the bonding/attachment relationship. Research in this area has now shown that although mothers are important sources of attachments for babies, they are by no means the only ones, and that any range of other carers can also develop healthy attachment relationships with babies that are important for them in both the short and long-term (fathers, grandparents, both mothers in lesbian parenting relationships, nannies/care workers, extended family members, etc.). Further, research has shown that babies benefit from having multiple healthy attachments, and this may be particularly important as these attachments can buffer baby when one parent struggles to develop a healthy attachment with the infant. We suggest rewriting to include this evidence and the importance of all carers developing healthy attachments with baby (this also reduces some of the mother’s felt pressure to “be all” to the baby). Barker, B., Iles, J. E., & Ramchandani, P. G. (2017). Fathers, fathering and child psychopathology. Current	members. However, the committee agreed to focus the review protocol to mother and baby attachment, thus only studies pertaining to this relationship are included in the review. That being said, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

				opinion in psychology, 15, 87-92. Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. Jama, 303(19), 1961-1969	
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Evidence Review O	12	General	Mental health is touched upon in PTSD but depression, probably the most common morbidity of the perinatal period that is known to impact on bonding, is not mentioned specifically. Does not cross reference NICE guidance AN and PN mental health.	Thank you for your comment. The "benefits and harms" section of the review addresses general mental health issues in the postnatal period that can affect bonding, however as no specific recommendations were made for women with depression, we haven't elaborated on specific mental health conditions. As suggested, specific recommendations cross-referencing to NICE guideline on antenatal and postnatal mental health have been added to the guideline under the assessment and care of the woman.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Evidence Review P	General	General	The committee could consider analysis by ethnic group – cultural sensitivity is mentioned in information and support but not in interventions. The BABCP/IAPT BAME Positive Practice Guide may be helpful to refer to also: https://babcp.com/Therapists/BAME-Positive-Practice-Guide-PDF Given a high prevalence of psychotropic medication use in general population – we suggest signposting women to latest information on safety when breastfeeding. This section could cross reference NICE guidance AN and PN mental health (CG192).	Thank you for your comment. Only 3 studies included in review P reported on the ethnicity of participants and the committee therefore agreed they did not have the basis on which to make specific recommendations in relation to breastfeeding interventions. However as you say, they did recommend that when providing breastfeeding support, this should be done in a way that respects cultural influences (as well as preferences). In terms of your suggestion to refer to the NICE guideline on antenatal and postnatal mental health, the committee did do this in the draft recommendations although instead of making this specific to breastfeeding, they signposted to this guideline to support the assessment of the woman's psychological

					and emotional wellbeing at every postnatal care contact. They agreed this would ensure that considerations about mental health are included at every contact, including although not exclusively, during conversations about or support for breastfeeding.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Guideline	5	001 - 002	“discuss the timing of transfer to home care with the woman, asking her about her needs, preferences and support available to her.” Suggest that emotional well-being is discussed at this point as part of asking about woman’s needs, to emphasize a holistic health approach. This may include recognition that emotions may vary widely at this point, reassurance, and reference to midwife and health visitor’s home visit as an opportunity to discuss further (1.1.6).	Thank you for your comment. The committee agrees that emotional wellbeing should be discussed and this is covered by the first recommendation in this section about assessing woman's health. The recommendation in this section does not list all the various aspects of woman's health that should be assessed, instead it refers to recommendations about the assessment of the woman's health which includes emotional and psychological wellbeing. We have also added a recommendation about providing information about the postnatal period, what to expect, what support is available (both statutory and voluntary sector) and who to contact if there are concerns.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Guideline	6	15	Reference NICE CG 192 (Antenatal and Postnatal Mental Health). Formal depression/mood screening should not occur at this visit given high rates of baby blues in first two weeks postnatal.	Thank you for your comment. There is a recommendation about assessing the woman's emotional and psychological wellbeing at each postnatal contact and a cross-reference is made to the section in CG192 where the depression and anxiety screening is recommended.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Guideline	8	011 - 012	At each postnatal contact, assess the woman's psychological and emotional wellbeing. It is useful to have NICE CG 192 mental health assessment recommendations mentioned here, but to ensure clinicians can have clear beginning steps easily spelled	Thank you for this comment and the suggestion, however, we tend not to repeat recommendations covered by other guidelines. Postnatal mental health was not reviewed by this guideline committee,

				out, consider suggesting at this point recommending that clinicians use the 2-item Whooley questions (as per NICE CG 192 guidelines, and further supported in recently NIHR funded research – see Howard et al. 2018) and then following further assessment guidelines from NICE CG 192 where indicated. Howard, L. M., Ryan, E. G., Trevillion, K., Anderson, F., Bick, D., Bye, A., ... & Milgrom, J. (2018). Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. The British Journal of Psychiatry, 212(1), 50-56.	therefore, we give direct reference to NICE CG192.
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Guideline	17	010 - 011	We welcome this overall section, and agree with the GDG that although there is limited evidence about what support development of attachment, the research on the longitudinal effects of attachment on child outcomes strongly supports its inclusion in this guideline. “Discuss with parents the potentially challenging aspects of the postnatal period that may affect bonding and emotional attachment” There is research showing some women struggle with high and perfectionistic expectations of needing to bond with their infant, and their high standards can cause them distress. Consider adding a bullet point to 1.3.16, “high personal, familial and cultural parenting” Rosan, C., Finnis, S., Biaggi, A., Pawlby, S., & Pariante, C. (2016). Perfectionism as a warning sign for postnatal mental health difficulties. Journal of Health Visiting, 4(8),	Thank you for your comment. The committee agrees that this could be an issue to some parents, however, the list is not attempting to be exhaustive but point to some of the most common types of challenges in the postnatal period. Demands of parenthood, for example, could encompass the issues you mention. The references you share are interesting, however, they do not fit the inclusion criteria for our reviews and have therefore not been reviewed.

				400-406. Also, given research on sharp declines in relationship satisfaction following birth of baby, and impact of couple conflict on child outcomes, consider adding a point about: “partner relationship” Ramchandani, P., & Psychogiou, L. (2009). Paternal psychiatric disorders and children's psychosocial development. The Lancet, 374(9690), 646-653.	
British Association of Behavioural and Cognitive Psychotherapies (BABCP)	Guideline	25	004 - 011	We welcome the inclusion of this section, in addition to the breast-feeding section. Given the research demonstrating that women who expected to breast-feed but struggled to do so and formula-fed instead is a predictor of mental health problems (whereas not expecting to breast-feed and subsequently formula feeding is not associated with subsequent mental health problems), consider adding a bullet point here: “provide emotional support to women who may express distress around their decision to bottle feed” Borra, C., Iacovou, M., & Sevilla, A. (2015). New evidence on breastfeeding and postpartum depression: the importance of understanding women’s intentions. Maternal and child health journal, 19(4), 897-907.	Thank you for your suggestion, which the committee discussed. They agreed not to make this change because they felt it may be unhelpful to anticipate that women might be negatively affected by choosing to formula feed. However the recommendations do highlight that supplementing breastfeeding with formula is an option so parents do not have to feel they must make a choice over one or the other method. Furthermore, they agreed to amend the recommendation under 'General principles of babies' feeding' to state more clearly that healthcare professionals should acknowledge parents' concerns around emotional, social and other impact that feeding options might have. In addition there is a recommendation to provide face to face support for parents who formula feed as well as supplementary written, digital or telephone information.
British Dietetic Association	Guideline	14	001 - 024	There is no mention of observing a breastfeed/bottle feed at this assessment. This should be part of the guidance to help spot any potential concerns early on (e.g. poor latch, tongue tie etc.) and involve the help of the infant feeding team / lactation	Thank you for your comment. Feeding assessment is part of the routine postnatal contacts. More details about breastfeeding assessment is covered by a different section of the guideline.

				consultant if necessary, and also to reassure parents of their feeding practices.	
British Dietetic Association	Guideline	14	025 - 027	1st week and 8th week Health Visitor check includes weight and head circumference, but not length. It would be really good to have length since length is not routinely measured at birth, and when babies are referred to dietitians with faltering growth, not having that parameter leaves gaps in growth monitoring.	Thank you for your comment. The NICE guideline on faltering growth as well as the UK-WHO Growth Charts recommend measuring length if there are concerns about faltering growth. Length measurement in the first weeks is not recommended routinely.
British Dietetic Association	Guideline	15	001 - 002	If growth is only to be measured using weight and head circumference as stated on lines 25-27 with a clear omission of length, then faltering growth may not be immediately evident. There is evidence to say that head circumference is a good marker for lean growth but it is also known that when growth falters, weight centiles drop first, then length and then head circumference. If clinicians wait until a drop in head circumference is seen before identifying faltering growth, the infant could be severely malnourished.	Thank you for your comment. The NICE guideline on faltering growth as well as the UK-WHO Growth Charts recommend measuring length if there are concerns about faltering growth. Length measurement in the first weeks is not recommended routinely.
British Dietetic Association	Guideline	24	002 - 003	This isn't clear on which professional should be assessing a breastfeed and it leaves this role open to interpretation, as well as leaving a lack of accountability. In the first instance a Health Visitor should assess breastfeeding concerns and if they are unable to solve these concerns the Health Visitor should contact the infant feeding team where a lactation consultant can provide further support.	Thank you for your comment. We have not defined the professional who would be providing breastfeeding support and we think this could be a midwife, a health visitor, a GP, or sometimes an infant specialist or lactation consultant. We have added to the recommendations that if there are ongoing concerns, a referral to additional support such as lactation consultant should be considered.

British Specialist Nutrition Association (BSNA)	Evidence Review T	17	035 - 037	The committee suggest '…it would not be feasible or practical to provide information about formula feeding to women who are not considering it and who express they want to exclusively breastfeed'. According to the high-quality research, as referenced on page 14 and 15 of this review, parents are seeking open information about formula feeding and breastfeeding in the antenatal period, including antenatal clinics. Considering we know that during pregnancy many mothers decide they wish to breastfeed, but that breastfeeding rates quickly diminish after 6 weeks, not providing any guidance on formula feeding during the antenatal period means that a large number of mums have no prior guidance about formula feeding which can lead to them feeling unsupported. Considering research indicates that parents are seeking this information, it's strange that the committee has not decided to recommend this (they only recommend formula feeding guidance for mums that have already chosen to formula feed during pregnancy).	Thank you for your comment. In addition to women who have already chosen to formula feed during pregnancy, the committee also recommended providing information on formula feeding to women who were considering formula feeding, whether exclusively or in combination with breastfeeding. The committee discussed that during the antenatal period there is a lot of information provision on issues in addition to feeding that the woman needs to consider, therefore where women who have expressed that they want to exclusively breastfeed, their choice should be respected and antenatal information on formula feeding shouldn't be provided unless requested.
British Specialist Nutrition Association (BSNA)	Evidence Review T	18	001 - 002	The report says, 'the committee agreed that parents should be provided with a one to one discussion about safe formula feeding.' However, no further details are given as to when this conversation should happen and with which healthcare professional? Would like to see further specifics to this point.	Thank you for your comment. The evidence review did not identify any themes pertaining to the timing of a one to one discussion about safe formula feeding therefore no specific information is provided in the evidence report. However, in the recommendations we state that discussions around formula feeding with those who need to formula feed or those who are considering should start in the antenatal period and

					continue in the postnatal period. Exact content of the discussion at different stages may depend on the situation.
British Specialist Nutrition Association (BSNA)	Evidence Review T	18	036 - 038	The committee agreed that in practice healthcare professionals would be able to draw on their own knowledge and expertise to provide information about the differences between breast milk and formula milk. The committee agreed that this is a key issue that should be covered by information being provided. This fails to consider the fact that many healthcare professionals feel that they cannot educate themselves on the topic of formula feeding due to peer to peer pressure not to discuss formula. In some cases, education about formula is something that is often done in their own time. Therefore, suggesting that this topic is something that HCPs should be knowledgeable about is unrealistic.	Thank you for your comment, which the committee discussed. On the basis of their practice knowledge they are confident that health care professionals caring for women and babies in the postnatal period (including but not exclusively health visitors) would be taught - both pre and post qualification - to be able to provide key information about feeding options. In relation to formula feeding (and in line with the Baby Friendly Initiative) this includes information about responsive formula (as well as breast) feeding and safe preparation and storage of formula or expressed breast milk. Teaching related to feeding therefore does address the differences between the feeding options and the key information described in the guideline.
British Specialist Nutrition Association (BSNA)	Evidence Review T	18	044 - 048	‘The committee recommended that parents who chose to formula feed should be informed about first infant formulas (including how to interpret the nutritional info on labels between different brands), how to prepare formula (including practical demo if necessary), and the volume of milk required. Further information is needed on where this information should be obtained, which HCPs should be providing this information and what are acceptable sources of such information?	Thank you for your comment. The committee recognises that there are various sources and providers for information on nutritional interpretation and preparation of formula, which may differ across health trusts in the NHS. In view of this the committee didn't specify where or who would be providing this information and support, but rather that it would be decided at local level.

British Specialist Nutrition Association (BSNA)	Evidence Review T	19	003 - 006	'The committee therefore recommended that to ensure mothers felt supported and could make informed decisions about infant feeding, that mothers should get balanced information about breastfeeding and formula feeding and about the impact introducing formula feeding could have on breastfeeding'. Further information is needed on what is considered a balanced source of information.	Thank you for your comment. 'Balanced' in this context is intended to mean that the information should be fairly presented, exploring pros and cons of all options. The recommendations themselves state that parents should be supported to make informed decisions and examples are provided of the specific issues about which parents would benefit from advice and information when planning infant feeding.
British Specialist Nutrition Association (BSNA)	Evidence Review T	General	General	A number of the studies used are 10-20 years old, or more, with very few which provide an insight into the last 5 years. Older studies are unlikely to provide an accurate and reliable overview/insight of the current situation around formula feeding.	Thank you for your comment. We agree that not all the studies are current. In addition to the evidence review the expertise and experience of healthcare professionals working in clinical practice is used to formulate recommendations.
British Specialist Nutrition Association (BSNA)	Evidence Review T	General	General	While we appreciate the postnatal period is general considered to be 6-8 weeks after birth, breastfeeding rates typically drop off around this time, with most women in the UK ceasing breastfeeding by 6 months. What consideration is given to guidance on formula feeding for post-8 weeks, in order to support these women?	Thank you for your comment. The scope of the guideline covers postnatal care up to 8 weeks after birth, therefore recommendations focus on this period.
City, University of London (School of Health Science)	Evidence Review B	8	002 – 005	Theme 5 of the evidence review (previous care/experience) links in with Theme 1 of our paper (Olander 2019), which also touches on the value of supportive/individualised care. Theme 3 of our paper (MW-HV collaboration for tailored care) is also a good fit with this evidence review (specifically Themes 1, 2 and 6) where we reported on women's views that information on their health status should be shared through centrally-held records.	Thank you for your comment. As noted, the Olander paper has been included in the evidence review and supports existing themes, namely theme 1, 2, and 6. We have not made any changes to the evidence review because it would not influence the overall conclusions, nor the recommendations made on the basis of the evidence. To some extent a little subjectivity is to be expected in a qualitative review with two reviewers potentially identifying slightly

					different data as having relevance to a review finding. The important point is that Olander was included and the findings made a valuable contribution to the review as a whole and in turn to the recommendations drafted by the committee.
City, University of London (School of Health Science)	Evidence Review B	General	General	We were excited to see our paper (Olander 2019) included in Evidence Review B [information transfer] but think this reference may also be relevant – Aquino, M. R. J. V., Olander, E. K., & Bryar, R. M. (2018). A focus group study of women's views and experiences of maternity care as delivered collaboratively by midwives and health visitors in England. BMC Pregnancy and Childbirth, 18(1), 505.	Thank you for your comment. The study by Aquino et al 2018 doesn't meet our inclusion criteria as there are no themes specifically reporting on information to be transferred between different heathcare teams.
City, University of London (School of Health Science)	Guideline	6	005 - 006	When should additional health visitor appointment be offered? More specificity would be helpful. Should it be before the 7 days after midwifery care has ended?	Thank you for your comment. Yes, the potential additional 'early' visit should be before the 'normal' postnatal health visitor visit but the exact timing depends on individual circumstances and local arrangements and we have not commented on this.
City, University of London (School of Health Science)	Guideline	6	008 – 019	Prompt and effective transfer of information (1.1.6) is crucial to ensure safe and appropriate care. How this is done in practice is not known. The current draft document acknowledges that there is variation in practice. So we urge the committee to also develop a research recommendation regarding increasing the understanding on how information is transferred and its impact on care provision and satisfaction.	Thank you for your comment. The committee agree with you about the importance of effective information sharing. Unfortunately 'how' this is done was not a topic for review as part of the development of this guideline so we cannot draw a systematic conclusion about the available evidence. For this reason, the committee were unable to make a recommendation for research on this issue. They can only recommend future research on topics for which a systematic review of

					available evidence have been conducted as part of the development of the guideline.
City, University of London (School of Health Science)	Guideline	8	005 – 021	We suggest physical activity is included in healthy lifestyles.	Thank you for your comment. We have revised the text and added physical activity as suggested.
Down's Syndrome Association	General	General	General	We would highlight specialist training for all maternity professionals, accredited by The Royal College of Midwives, which is provided, free of charge, by The Down's Syndrome Association Tell it Right® Start it Right Down's Syndrome Association (downs-syndrome.org.uk)	Thank you for your comment. Specialist care is outside the scope of the guideline but we thank for the information.
Down's Syndrome Association	General	General	General	We would highlight a publication relevant to professionals providing postnatal care to women who have a new baby who has Down's syndrome www.downs-syndrome.org.uk/download-package/antenatal-neonatal-postnatal-care-guide-for-practitioners-2019	Thank you for your comment. Specialist care is outside the scope of the guideline but we thank for the information.
Down's Syndrome Association	Guideline	4	005 - 013	Where it is already known that a new baby has a condition (e.g. Down's syndrome) or where it is suspected that the baby may have a condition like Down's syndrome (and investigations are beginning) the new parent(s) are put into contact with specialist organisations like The Down's Syndrome Association who can provide information and support. Frequently new parents find their own way to us, rather than this being facilitated by a healthcare professional.	Thank you for your comment. Specialist care is outside the scope of this guideline.

Down's Syndrome Association	Guideline	5	009 - 012	Where it is known (or suspected) that a new baby has a condition like Down's syndrome, make sure that this is communicated to relevant professionals supporting the new family. Sometimes new parents report that professionals interact with them on a maternity ward and it is clear that this information has not been shared and this can be upsetting new parents who feel there is a lack of joined-up working amongst the team.	Thank you. We appreciate the importance of this comment but specialist care is outside the scope of this guideline and we have therefore not commented on it.
Down's Syndrome Association	Guideline	6	002 - 004	Following on from our comments (1 and 2) above, make sure that health visitors who will be supporting a new mum and baby when they return home is aware of any potential diagnosis of a condition such as Down's syndrome, especially where investigations are still ongoing. It is not uncommon for new parents to report a community-based midwife or health visitor visiting them at home is unaware and that they have to take on the role of sharing this information. It would also be helpful if these health professionals could also have to hand details of support organisations (like The Down's Syndrome Association) and share this appropriately.	Thank you for your comment. The recommendation on communication between healthcare professionals at transfer of care covers this issue. We have further revised this recommendation to include that the plan of ongoing care, including long-term management should be communicated between the professionals. Specialist care as such is outside the scope of this guideline.
Down's Syndrome Association	Guideline	6	008 - 019	This should also include essential information about a condition (like Down's syndrome), where this is appropriate.	Thank you for your comment. The recommendation includes issues related to current pregnancy and birth and we have also added to the recommendation that information about planned care including long term management should be shared between healthcare professionals so we believe this is covered, however, specialist care is outside the scope of this guideline

					and have therefore not commented on the issue of Down's syndrome specifically.
Down's Syndrome Association	Guideline	7	004 - 019	Include here other sources of support available to new families in the community, including Third Sector organisations.	Thank you for your comment. This recommendation is about communication with the woman. We have made references to providing information about available statutory, voluntary or peer support in other sections of the guideline.
Down's Syndrome Association	Guideline	10	006 - 008	Outline here specialist peer-to-peer support available from organisations that can facilitate communication with other parents who can share their lived-experience.	Thank you for your comment. We have not specified peer-to-peer support as such but have amended the recommendation to state that information about relevant support and birth reflection services should be provided if appropriate.
Down's Syndrome Association	Guideline	15	005 - 006	Ensure that, at this point, information is shared about any relevant ongoing investigations which may lead to the sharing of information about a genetic condition. If it is known that a new baby has Down's syndrome, it would be appropriate here to include specific details about development, including specific growth charts for babies and children with Down's syndrome www.rcpch.ac.uk/resources/uk-who-growth-charts-down-syndrome-0-18-years There are also specialist resources focused on development available from Early Support Downs Syndrome Development Journal - Early Support Council For Disabled Children	Thank you for your comment. Specialist care is outside the remit of this guideline. However, this point is covered by the recommendation on communication between healthcare professionals at transfer of care.
Down's Syndrome Association	Guideline	23	009 - 011	The benefits of breast-feeding for babies who have Down's syndrome are well understood, but it is often the experience of new mums that tailored advice to support	Thank you for your comment. Specialist care (care beyond routine postnatal care) for babies****with pre-existing conditions is not covered by the scope of the guideline.

				them in breast-feeding their new baby is overlooked.	
Elizabeth Bryan Multiple Births Centre	Guideline	6	001 - 006	First health visitor visit. Some women with specific difficulties or if the midwives have other concerns may need to see a health visitor sooner than 7 days. We suggest adding that this should be considered in such circumstances.	Thank you for your comment. This is a 'consider' recommendation, therefore, flexibility in special circumstances is expected if deemed beneficial. We have not changed the recommendation.
Elizabeth Bryan Multiple Births Centre	Guideline	30	1	Research recommendation 5 Breast deeding support for parents with twins or triplets; We welcome this but suggest it is changed to " Feeding support…. not just breast feeding.	Thank you for your comment. Based on the NICE guideline development manual, research recommendations can only be done for topics that the committee looked for evidence on and did not find or the evidence was limited or inconclusive. The committee specifically looked for evidence on breastfeeding support for twins and triplets but did not identify any relevant research. Therefore, the guideline committee prioritised breastfeeding support for parents with twins or triplets as a research recommendation.
Elizabeth Bryan Multiple Births Centre	Guideline	General	General	As multiple births were not specifically included or excluded in the scope for this Guideline, we presume the GDG made the decision not to include specific references to multiple births in the recommendations. However the postnatal care of women who have a multiple birth needs some specialist input. This includes feeding, supporting women with preterm twins or triplets, babies discharged separately or in the neonatal unit, higher risk of depression and more complex relationships with the babies. The NICE Guideline Multiple Pregnancy 129 (2011)	Thank you for your comment. Postnatal care for twins and triplets were covered in selected reviews in this guideline: How does length of postpartum stay affect women and their babies (twins or triplets)? (evidence review A); When should the first postnatal contact by midwives be made after transfer from place of birth to community care (twins or triplets)? (evidence review C); What interventions are effective in starting and maintaining breastfeeding (twins or triplets births)? (evidence review P); What information on breastfeeding do parents find

				and update NICE 137 Twin and Triplet Pregnancy (2019) cover antenatal, postnatal and intrapartum care and we would like to suggest that similar guidance is developed for postnatal care. We appreciate that a specific NICE Guideline may not be appropriate but there may be the possibility of extending the Guideline already published to include postnatal care. We would be pleased to discuss the options with the NICE team outside this consultation. We appreciate that much of the generic content in these recommendations can be applied to multiple births but remain of the view that rather than make a few additions separate guidance would be preferable.	helpful (twins and triplets)? (evidence review S); What support with breastfeeding do parents find helpful (twins or triplets)? (evidence review S). dence specific to twins or triplets was lacking in these topics so the committee agreed not to make recommendations specifically addressing twins and triplets. However, the committee agreed to make a research recommendation in relation to what support with breastfeeding do parents of twins or triplets find helpful.
Faculty of Sexual & Reproductive Health	Guideline	8	18	It is disappointing that, despite the importance of establishing contraception soon after childbirth to reduce risk of unplanned pregnancy, abortion and short interpregnancy interval, contraception is mentioned once in this document as a single word as a bullet point in a list of topics that may be included in discussion at post-natal contacts. No guidance or link to guidance is given.	Thank you for your comment. Contraceptive care or services are not covered by this guideline as stated in the scope of the guideline, however, we have added a link in the recommendation to the Faculty of Sexual and Reproductive Health guideline on contraception after pregnancy.
Faculty of Sexual & Reproductive Health	Guideline	8	18	Evidence Review [F] Content of postnatal care contacts points out that in recent months, there has been a change in practice to focus on postnatal contraception services within maternity services, but that increased training in needed to provide this. FSRH provides an Essential Contraception for Midwives training course, and it is expected that in the coming years there will be	Thank you for your comment. The scope of the guideline states that contraception care and services are not covered by this guideline so no detailed recommendations have been on this topic.

				significant growth in the number of midwives being trained to provide contraception advice. To support this positive change, it is vital that NICE guidance includes explicit guidance for postnatal contraception, with reference to the FSRH Guideline for Contraception after Pregnancy.	
Faculty of Sexual & Reproductive Health	Guideline	8	18	We recommend including as a new point in section 1.2: “At each postnatal contact, women should be given the opportunity to discuss their fertility intentions, contraception, and preconception planning.”	Thank you for your comment. Contraceptive care or services are not covered by this guideline as stated in the scope of the guideline.
Father’s Network Scotland	Guideline	8	005 – 021	There is evidence that a partner’s general wellbeing is intrinsically linked to a mother’s general wellbeing and the wellbeing outcomes for an infant. Evidence suggests that 99% of partners attend at least one antenatal appointment or scan, with 92% present at the birth. We recommend that “At each postnatal contact, ask the woman and the partner about her general health and whether she or he has any concerns, and assess her or his general wellbeing. “	Thank you for your comment. The focus of this guideline is on the postnatal care of the mother and the baby, however, we recognise the importance of partners. Partners should be involved according to the woman's wishes and this is stated in the guideline and we generally refer to parents when referring to the care of the baby.
Father’s Network Scotland	Guideline	8	022 – 024	There is evidence that between 10-15% of partners suffer from depression during the perinatal period. There is evidence that a partner’s mental health is associated with a mother’s mental health, and a mother’s ability to parent confidently and positively. There is evidence that a partner’s menta;l health is linked to outcomes for an infant’s mental and physical health and wellbeing, with family relationships and wellbeing outcomes, and with a partners’ ability to engage positively with a mother, infant and	Thank you for your comment. The focus of the guideline is postnatal care for women and babies, therefore assessment and care of the partners' health is outside the remit of this guideline.

				family unit. We recommend that " At each postnatal contact, assess the woman's and the partners' psychological and emotional wellbeing. "	
Father's Network Scotland	Guideline	10	006 - 008	We recommend, based on the above referred to evidence, that a partner as well as a woman should be given the appropriate opportunity and referral.	Thank you for your comment. The focus of this guideline is the postnatal care of the women and babies and while we recognise the importance of partners'/fathers' experience and wellbeing, this is outside the remit of this guideline. However, we have made a reference to the NICE guideline on antenatal and postnatal mental health which includes a section about birth trauma and these recommendations include taking into account the effect on the partner.
Father's Network Scotland	Guideline	27	004 - 006	Bonding and emotional attachment We are concerned that the emphasis on bonding and attachment describes only the bonding and attachment with relation to the "main carer – usually the mother. "We recommend that there is clear reference to the importance of bonding and attachment between the infant and a mothers' partner, which is supported by comprehensive evidence.	Thank you for your comment. We have revised this section and have specifically mentioned "parents" and that babies form attachments with a variety of caregivers but the first, and usually most significant of these, will be with the mother and/or father.
Father's Network Scotland	Guideline	34	014 - 016	"We recommend that issues that should be communicated between healthcare professionals at transfer of care, including the woman's and a partner's history in relation to" the same subsequent issues as a woman.	Thank you for your comment. It is important to understand that this is not an exhaustive list and there may well be some issues relating to the partner that are relevant to share and we would expect healthcare professionals to do so based on their professional judgment. However, most of the issues we specifically list here relate to the obstetric and clinical issues related to the woman and the baby. However, we have specifically added that information about who

					has parental responsibility of the baby should be shared which would often then include information about the father/partner.
Father's Network Scotland	Guideline	036 – 037	General	We recommend that this should include reference to consider communication with partners. There is ample evidence describing examples of good practice with relation to communication with partners, e.g. Kirkcaldy Health Visiting Practice in Fife, Scotland. We recommend that assessment and care of the partner is considered and outlined in this document. We are concerned as to the lack of reference overall to a partner's physical and mental health and wellbeing, and of guidance as to how to engage with and support a partner's physical and mental health and wellbeing. We are concerned overall as to the lack of reference and guidance with relation to the importance of supporting positive relationships between a mother and her partner.	Thank you for your comment. We recognise the importance of the partner's wellbeing on the wellbeing of the family as a whole. However, the focus of the guideline is postnatal care for women and babies, therefore assessment and care of the partners' health is outside the remit of this guideline. We have revised the guideline to include the word "partners" or "parents" (instead of just the woman/mother) where the committee considered this to be appropriate, in particular to the sections related to the baby's care or feeding.
Fatherhood Institute	Comment Form Question 1	N/A	N/A	*Q. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.* *Our Comments are solely in relation to better inclusion of fathers/ other caregivers in home visits and other interactions with healthcare practitioners (HCPs) in the immediate postnatal period. For reasons set out below (many backed up with evidence – mainly RCTs and systematic reviews), this is likely to have significant impact on maternal and baby health. As our suggestions are mainly in relation to HCPs showing interest in, and*	Thank you for your comment. The remit of the guideline is postnatal care for women and their babies but the committee has considered the involvement of partners or other parental caregivers throughout the guideline and some revisions have been made based on the stakeholder comments, including yours. Please see our responses to the individual comments for more details.

				talking directly to, the baby's father/ mother's partner (according to the mother's wishes – and in mainstream engagement with families, not through separate services), practitioners should not find this particularly challenging to implement once the requirement to do so is made clear to them in the Guideline.	
Fatherhood Institute	Comment Form Question 2	N/A	N/A	*Q. Would implementation of any of the draft recommendations have significant cost implications? A. There are.no significant cost implications, and there may be savings (Edoka et al., 2011): problems in families (including fathers' poor mental health, substance misuse or use of violence) will be more easily identified; the well documented benefits of father-involvement (Flouri, 2005) and services-engagement with them (Lundahl et al., 2008; Nunes et al., 2020)will be evident; mothers are likely to feel and be better supported (Di Mascio et al., 2008), their mental health to be better (Yargawa & Leonardi-Bee, 2015) and their babies safer (Dias et al., 2005); breastfeeding rates are likely to be higher (Abbass-Dick et al., 2015), and so on.*	Thank you for your comment. The remit of the guideline is postnatal care for women and their babies but the committee has considered the involvement of partners or other parental caregivers throughout the guideline and some revisions have been made based on the stakeholder comments, including yours.
Fatherhood Institute	Comment Form Question 3	N/A	N/A	*Q. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) A. Some training for healthcare providers, managers and front-line workers (e.g. online modules, PDF resources with research evidence, case studies) to help them understand WHY engaging with fathers/ other caregivers is*	Thank you for this comment and sharing these ideas.

				worth doing and HOW they can incorporate this into their usual care of the mother and baby, would enable HCPs to introduce the kinds of small but necessary practice adjustments that will address them, Even without training, the simple fact of NICE encouraging HCPs to engage directly with fathers and other caregivers is likely to impact on a wide range of practice guidelines, including competency frameworks.	
Fatherhood Institute	Comment Form Question 4	N/A	N/A	*Q. 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. A. The committee will need to find out how practice has changed due to Covid-19, and make recommendations on the basis of that, not least because some of the current changes may be retained – e.g. fewer postnatal visits 'in person'/ only one parent and baby attending a clinic. The Fatherhood Institute has a survey in field, identifying ways in which practice in perinatal settings across the UK has changed due to Covid, and how this is affecting mothers, fathers/ partners and HCPs. We will be happy to share our findings with the Committee, when published.*	Thank you for your comment. The committee discussed the changes they have noted during the Covid-19 pandemic, including more remote contacts. However, the view of the committee is that until there is evidence telling otherwise, face to face contacts (i.e. in person) should remain the primary mode of postnatal care visits beyond the pandemic. The qualitative evidence that was reviewed for this guideline indicated that remote contacts can be useful but should not replace face to face contacts. Some of the assessments would also not be possible to do in a remote contact.
Fatherhood Institute	Committee List	General	General	The committee developing the antenatal care guideline update includes a father – an individual who also has knowledge and understanding of research relating to fathers in the antenatal period. The committee developing the postnatal care update	Thank you for your comment. We are grateful for the stakeholders, including yourselves, who have given input on the issue of partner/father involvement during the consultation. The remit of the guideline is postnatal care for women and their babies,

				includes no such person, nor is this committee in receipt of expert testimony/ input on fathers/ partners. The Fatherhood Institute offered to fill this gap but no response from the committee was received. Several recommendations made by the committee were reached 'through informal consensus, based on their knowledge and experience'. Since this knowledge and experience did not extend to the influences/ experiences of the baby's father (or any other caregivers) it is not surprising to find several Committee discussions (as reported in Evidence Reviews) failing to mention fathers/ partners or downplaying the importance of their role. The Committee discussion reported in Evidence review F (Content of postnatal contacts) is one of these. Reliance on committee knowledge, experience and informal consensus was the more detrimental given the exclusion of father/ partner from inclusion criteria and/ or search terms for Evidence reviews informing this Guideline (see later Comments).	therefore, while we agree that the perspective of the partner/father in postnatal care is important, especially in relation to the care of the baby, the focus of the guideline remains on the care of the mother and the baby. That being said, the role of partners or parents (not just the mother who has given birth) were considered throughout the development of the guideline. Based on the stakeholder comments the committee has revised the recommendations. For example, we have added the word 'parents' or 'partner' to the recommendations, where appropriate, and have added a recommendation acknowledging the right for those with parental responsibility to be involved in the care of the baby, if they so choose. Please see individual responses to later comments on specific issues.
Fatherhood Institute	Evidence review O	5	007 - 017	Inconsistency: wording hovers between SINGULAR and PLURAL 'Emotional attachment . . . is the earliest relationship (SINGULAR) that a child develops with their primary caregiver(s) (SINGULAR & PLURAL). It is affected by the primary caregiver's (SINGULAR) behaviour' 'Bonding is the positive emotional and psychological connection that the primary carer(s) (SINGULAR + PLURAL), usually the mother, develops with the baby'.	Thank you for highlighting this. While finalising the guideline for publication all instances of singular and plural usage have been reviewed and we are confident there are no longer any inconsistencies.

Fatherhood Institute	Evidence review O	6	General	'Critical' and 'Important' Outcomes': only baby-mother attachment has been addressed, when some of the baby outcomes result from quality of care provided by other caregivers, too. This should be made clear (i) Mother's feelings towards the baby when the baby is 12 to 18 months of age (MOTHER) (ii) Quality of mother-baby interaction when the baby is 12 to 18 months of age (MOTHER) (iii) Proportion of babies displaying an insecure attachment type (which includes ambivalent, avoidance, disorganised) when the baby is 12 to 18 months of age (MOTHER not specified – infants and young children develop multiple attachments to major caregivers, security of which may vary in relation to individual caregivers (Lamb & Lewis, 2010)) (iv) The nature of the early mother-baby relationship (based on the mother's subjective perception) when the baby is 12 to 18 months of age (MOTHER) (v) Social behaviour of the baby when the baby is 12 to 18 months of age (likely to have resulted from interactions with all major caregivers, not solely the mother)	Thank you for your comment. We agree that for outcomes (iii) and (v) interactions from other caregivers could contribute to the effect of the intervention. Nonetheless, this will have been taken into account in the study design, where confounding factors (such as interaction with other caregivers) will have been addressed through randomisation or adjustment in analyses and reflected in our quality assessment of included studies.
Fatherhood Institute	Evidence Review O	066 – 069	General	Exclusion of papers relating to fathers Three papers relating to bonding/ attachment in fathers (Hay et al., 2018; Magill-Evans et al., 2006; Mihelic et al., 2018) were considered). Two of the three may have been excluded on the basis of the evidence review's narrow inclusion criteria which excluded father-infant attachment outcomes. The third was a conference presentation, about which there	Thank you for your comment. We acknowledge that there are other sources of attachment for babies other than the mother e.g. father, mother's partner, other family members. However, the committee agreed to focus the review protocol to mother and baby attachment, thus only studies pertaining to this relationship are included in the review. That being said, we will pass your comment

				was no information (even an abstract). However, we cannot understand why only those studies, and not others about father-infant attachment, were found through the search strategy for this Evidence review – see next Comment,	to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Fatherhood Institute	Evidence review O	General	General	In relation to whether bonding/ attachment applies to one infant-carer relationship or to more-than-one, wording in both Evidence review O and the Draft Guideline is unclear, and sometimes contradictory. This issue needs to be resolved if HCPs are to know whether they are to look only at bonding/ attachment in relation to mothers or more widely in the family. We address some of these inconsistencies in subsequent Comments.	Thank you for your comment. The committee considered your point carefully and they felt it was already clear that the importance of bonding and emotional attachment should be discussed with parents (not just mothers) before and after birth. They had already also recommended that parents (not just mothers) be encouraged to value the time they spend with the baby as a way of promoting emotional attachment. The committee did however revise a recommendation to say that the different approaches that can help with bonding should also be discussed with parents.
Fatherhood Institute	Evidence Review O	General	General	Relevant research identified by the Fatherhood Institute that should have been considered for Evidence review O: There is a substantial literature on fathers and attachment (none of it considered for this Evidence review) including RCTs of interventions that have impacted positively on infant-father attachment security through: father-newborn skin-to-skin contact (Chen et al., 2017); neo-natal bathing/ massage (Scholz & Samuels, 1992); video interaction guidance (Hoffenkamp et al., 2015) and the SAFE® attachment-promoting programme (Walter et al., 2019). In an RCT of a parent empowerment programme in a NICU,	Thank you for your comment. We acknowledge that there are other sources of attachment for babies other than the mother for example fathers, partners and other family members. However, the pre-specified protocol limits attachment to mother and baby, thus only studies pertaining to this relationship are included in the review. Therefore the references you have provided have not been included in Evidence review O as they do not meet the inclusion criteria. That being said, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

				blinded observers judged intervention fathers (and mothers) as more positive in interactions with their infants (Melnyk et al., 2006). We are also aware of RCTs of interventions that have impacted positively on factors likely to have negative impacts on infant-father attachment: new fathers' mental health (Charandabi et al., 2017; Melnyk et al., 2006), parenting stress (Cowan et al., 2014) and psychological distress (Daley-McCoy et al., 2015). Infant-father and infant-mother attachments are impacted by factors outside the dyadic relationship – and very often related to their child's other parent. For example: Infant-mother attachment has been found to be less secure when the baby's father uses violence (Levendosky et al., 2011) and when he is a heavy drinker (Eiden et al., 1999). Direction of effects can flow either way: a systematic review found a correlation between maternal depression postnatally and the father's negative perceptions of infant temperament (Keeley-Jones, 2012). An RCT found mother-foetal attachment security positively impacted by training fathers to recognise and promote secure attachments (Akbarzade et al., 2014), and it would seem reasonable to assume that such training provided to fathers postnatally would have similar impact. The relevance of the couple relationship to security of infant-parent attachments is well documented – another reason that the bonding/ attachment recommendations in the Guideline should	

				take both parents into account. Couple conflict both before and after the birth has been found to predict insecure infant-mother and infant-father attachments (Owen & Cox, 1997) Interparental hostility during family play at infant age six months predicts less secure attachments between pre-schoolers and their mothers (Frosch et al., 2000) RCTs we identified that impacted positively on the couple relationship across the transition to parenthood (Cowan et al., 2014; Schulz et al., 2006) are likely to have positively impacted both infant-father and infant-mother attachments. Also significant to infant wellbeing and development is 'positive coparenting' – i.e. the capacity of the parents to operate as a well-functioning parenting team. An RCT of a perinatal group intervention found that thus had significant impact on coparenting as well as a number of related factors, including reducing family violence (Feinberg et al., 2016)	
Fatherhood Institute	Evidence Reviews	General	General	Among the Evidence reviews that we have been able to examine in detail, we found father/ partner not included in any of the following, to all of which they are highly relevant – including to those about which we have not commented in any detail, below): Evidence review A: Length of postpartum stay Evidence review C: Timing of first postnatal contact by midwife Each of the 'timing' evidence reviews (Evidence reviews C, D, E) pre-defined specific subgroups of women and other factors that would be incorporated into subgroup and	Thank you for your comment. The committee discussed at length your point about the importance of considering fathers and their needs. As a result they made a number of changes to recommendations, for example a new section on 'principles of care', which refers in greater detail to the involvement of fathers and added emphasis on communication with fathers, particularly as this relates to the care of the baby, including the provision of information about feeding. In terms of the specific needs of fathers following birth, these are not within the scope

				sensitivity analyses - i.e. to investigate whether these subgroups/ factors affected the impact of the timing on outcomes. These factors included the 'content of visit/ assessment'. BUT the defined subgroups/ sensitivity analyses did not include whether the woman had a partner, nor whether the woman had support available from the partner/ elsewhere. So, impact of/ support from baby's father/ woman's partner missing from all of these – and also from Evidence review A, where the support available to the mother and baby at home must surely inform hospital discharge. Evidence review D: Timing of first postnatal contact by health visitor: Father/ partner is not included in the search terms, despite the fact that the specified outcomes include (i) Identification of safeguarding concerns (ii) Emotional attachment between 'parent' (i.e. not solely mother) and baby when the baby is 12 to 18 months of age (iii) Proportion of 'parents' (not solely mothers) satisfied with their postnatal care. Evidence review E: Timing of comprehensive assessment Evidence review F: Content of postnatal care contacts: Here, the search strategy for finding systematic reviews included the terms 'father' and 'partner'. But neither the cited included nor excluded systematic reviews included the many systematic reviews that the Fatherhood Institute knows exist about fathers in the perinatal period (e.g. their mental health), some of which we have cited in our Comments here – and most	of the guideline, which focuses on the care of women and babies from the birth of the baby until the end of the postnatal period. Therefore none of the evidence reviews focussed specifically on father's needs, which is why, as you correctly highlight, terms relating to fathers and partners are lacking from the search strategies.

				of which have Full Texts easily found online. Had those systematic reviews been included, they could have influenced the guideline recommendations on content of professional contact. Evidence review F is the review used as the basis for guideline recommendations on the content of visits. The review question was What is the essential content of postnatal care contacts for women and babies? i.e. the review assumed from the start that these contacts do not also involve fathers (although, in point of fact, midwives and health visitors meet huge numbers of fathers); and do not incorporate positive father outcomes and positive father-infant attachment among their objectives. Furthermore, issues considered included Provision of advice and information for parents or immediate family and Assessment of the support available to the mother and baby from the partner or family YET Formal consensus techniques among the Committee (which included no father/ partner) discarded, for reasons that are not clear, the following statements in the literature: (i) Assessment of the support available to mother and baby from the partner and family (ii) At every postnatal care contact ask women what family and social support they have (56% - discarded after round 1) (iii) Observe relationship or family dynamics by involving the woman's partner and/ or support network during postnatal care contacts (75% - carried forward to	

				round 2) but not ultimately included in the Draft Guideline) Evidence review G: Content of postnatal care contacts The review question was: When and how should information be given to mothers and their partners about postnatal health of the mother? And the introduction included the sentence Providing information related to a woman's postnatal health addresses the needs of mothers and their partners. Yet none of the evidence gathered/ included mentioned partners; and consequently, the Draft Guideline made no mention of them although, as we indicate in other Comments, informing the partner is potentially protective of the woman's health. Evidence review M: Benefits and harms of bed sharing Evidence review O: Emotional attachment (detailed Comments on Evidence review O elsewhere in this submission) The result of failure to include father/ partner is that robust research evidence including from systematic reviews, longitudinal studies, RCTs and Serious Case Reviews that would have usefully informed Recommendations is missing from the evidence base that informed the development of the Draft Guideline. In fact, overall, this Draft Guideline is far less evidence based than others we have examined, relying overly on Committee consensus due to overly narrow evidence reviews, despite the postnatal period being so well evidenced in international research.	

Fatherhood Institute	General	General	General	While the 2006 Guideline was far from being a blue-print for father-inclusive practice, it pays far more attention to fathers'/ partners' roles in maternal and infant health than the 2020 Draft Guideline update. This is puzzling given the rapid rate of increase, decade-on-decade, in fathers' hands-on-care of infants and young children in the UK (Henz, 2017), as well as increasing interest worldwide in engaging with fathers in the perinatal period (Teitler, 2001; Tokhi et al., 2018; WHO, 2015; Yargawa & Leonardi-Bee, 2015), not least as a means of better achieving MDG 5 (5th Millennium Development Goal – Improve Maternal Health) (Singh et al., 2014) and SDG 3.4 (Sustainable Development Goal - reducing NCD mortality/ improving mental health and wellbeing (Modi & Hanson, 2020)). Some 2006 v. 2020 comparisons: 2006: 'At each postnatal contact . . . Women and their families/ partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.' Our observation: partner recognised as a key conduit to information about the woman's wellbeing 2020 'At each postnatal contact, ask the woman about. . . ' Our observation: no mention of partner or families 2006: Rec. 1.4.6 'Home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment.' Our observation: emotional attachments between baby and other	Thank you for your comment. The remit of the guideline is postnatal care for the woman and her baby, although we recognise the role of the partner/father/other parental caregiver in this. As a general principle, the guideline says that the woman may be supported by a partner and they should be involved according to the woman's wishes. Furthermore, we have now revised the guideline to specifically state that those with parental responsibility have the right to be involved in the care of the baby if they choose. We have also revised the guideline and added 'partner' or 'parents' to the recommendations where considered appropriate. We have also defined what these terms mean in the context of this guideline in the 'Terms used in this guideline' section, mentioning that these can mean the father of the baby. Because there any many different kinds of family arrangements, 'partners' or 'parents' were considered more inclusive than referring to 'fathers'.

				caregivers clearly considered relevant 2020: Our observation: the 2020 Draft Guideline update is far more ambivalent about whether infant-father attachment/ bonding is to be supported by HCPs – see detailed Comments below. 2006: Rec. 1.4.9 'Healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit. Our observation: the term father is used here – and at other points in the 2006 Guideline 020 Draft Guideline Our observation: the term 'father' is never used in the 2020 Draft Guideline.	
Fatherhood Institute	General	General	General	IN LIGHT OF our Comments above, both general and specific, we wish to challenge the validity of this whole Draft Guideline on the basis of Scope limitation Incomplete evidence and review methods Committee expertise/ composition Inadequate response to stakeholder comments in the Consultation (2017) on the draft scope for this Guideline Failure to observe the rights of all parents and carers, as set out in the, NHS Constitution, to be involved in planning and making decisions about their baby's health and care Failure to address fathers/ women's partners as an 'under-served group' (NIHR definition) Failure to include the term 'father' in the Draft Guideline	Thank you for this comment and other comments highlighting the importance of father/partner involvement in postnatal care. We appreciate that you feel that the scope of the guideline was limited in terms of fathers, however, the scope that was agreed based on stakeholder consultation at the time was the basis from which the guideline committee worked on. However, partner involvement, in particular in relation to the care of the baby, was considered throughout which is why we often refer to 'parents' instead of the 'woman' or 'mother'. Based on the stakeholder comments, we have now revised the guideline and added 'partner' or 'parents' to further recommendations where considered appropriate. We have also defined what these terms mean in the context of this guideline in the 'Terms used in this guideline' section, mentioning that these can mean the

					father of the baby. Because there any many different kinds of family arrangements, 'partners' or 'parents' were considered more inclusive than referring to 'fathers'. We hope that the revisions and our responses to your comments will answer some of the concerns raised.
Fatherhood Institute	Guideline	1	5	The Draft Guideline says: For simplicity of language, this guideline will use the term 'woman' or 'mother' throughout Our observation: Members of our team were confused by this. They could not understand why the two different terms (woman/ mother) were being used. Having thought carefully about this, we think the Draft Guideline uses the term 'woman' when referring to her own health/ well-being; and the term 'mother' when referring to her in relation to her baby. Our recommendation: The use of these terms should be explained – see our suggested re-draft of this sentence in the paragraph re-draft at the end of this Comment. The Draft Guideline says Similarly, where the term 'parents' is used, this should be taken to include other people who are the baby's primary caregivers and single parents. Our observations: (i) The first problem here is the inclusion of 'single parents' in the definition of 'parents. 'Parents' as it is used here is the plural of 'parent'. 'Parent' as used in 'single parents' here is as a synonym with 'mother'. However, single mothers in this Guideline will be subsumed into 'woman' or 'mother'. They should not be included in this definition	Thank you for your comment. We have clarified the issue about when the term 'woman' and 'mother' are being used. We have also added a definition of 'parents' to the 'Term used in this guideline' section to clarify what is meant by this term in the context of this guideline and have stated that often this mean the mother and the father. Generally, in relation to the care of the baby we refer to parents, rather than the mother and/or father as we recognise the various family arrangements that people live in. Where we refer to parents, this also then means lone parents and we have made this clear in the definition. We have revised the guideline and avoided using the term 'primary caregivers' and instead refer to either parents or parental caregivers.

				of ‘parents’ (ii) The term ‘primary caregivers’ is also problematic. The OED definition of ‘primary’ carer is ‘The person (SINGULAR) who provides the majority of care or guardianship, especially to a child or an infirm person’. In relation to eldercare the term ‘primary carers’ (PLURAL) is used to refer to individuals who are primarily responsible for the elderly person at different times of day or night – and who are therefore sequentially ‘primary carers’). In the extensive literature relating to infants and young children the term ‘primary caregiver’ refers to one person, usually the mother. Primary caregivers (PLURAL) would normally refer to primary caregivers from different families rather than to two or more caregivers from one family. (iii) Also, problematic / insufficient is the way the Guideline defines parents – i.e. without including the word ‘father’ (see previous Comment). Our recommendation: To sum up, we suggest the following wording for this paragraph For simplicity of language this Guideline will use the term 'woman' (when referring to the woman’s own health/ wellbeing) and 'mother' (when referring to her in relation to her baby) throughout. The terms ‘woman’ and ‘mother’ should be taken to include people who do not identify as women but who have given birth. ‘Mother’ will refer to mothers who are partnered or who are parenting alone (‘Single’ Mothers - i.e. where the mother has no cohabiting or non-cohabiting partner). Where the term	

				'parents' is used, this should be taken to refer to the mother plus her baby's father/ other people who provide parental care to the baby.	
Fatherhood Institute	Guideline	4	General	Parents' 'rights' 'Parents and carers have the right to be involved in planning and making decisions about their baby's health and care, and to be given information and support to enable them to do this, as set out in the NHS Constitution and summarised in NICE's information on making decisions about your care.' Despite this statement in the Draft Guideline, fathers'/ partners' rights are not upheld in this Draft Guideline: for example, only women/ mothers are mentioned in respect of planning for their baby's health and care, and in being given information and support to enable them to do so (other than, partially, in breastfeeding – see our Comments on breastfeeding below).	Thank you for your comment. We have now added a recommendation acknowledging the right that those with parental responsibility have in relation to the care of the baby. We have also added a definition of 'parents' and 'partners' including these often mean/include the father of the child but we recognise there are different family arrangements.
Fatherhood Institute	Guideline	5	001 - 002	Our suggestion Amend to read: Discuss the timing of transfer to home care with the woman (and her partner, if present), asking about needs, preferences and support available to her. Our rationale: The capacity of the father/ woman's partner to provide physical and emotional support is clearly key to the timing of transfer to home. Speaking directly with an HCP helps them understand what will be required of them, and also enables the HCP to better assess where support for the mother and baby will be inadequate and to identify any safeguarding issues	Thank you for your comment. We have not specifically mentioned partners in this recommendation because the overall recommendation about involving the woman's partner according to her wishes applies to this recommendation as well. The committee felt it was important that the timing of transfer to community care is based on clinical indications and the woman's preferences and needs, not the partner's as such, but if the woman wants to involve their partner in the discussion, this should happen (as per the recommendation about partner involvement) but not as a default.

Fatherhood Institute	Guideline	5	5	*. . . safeguarding issues (also see the NICE guideline on domestic violence and abuse). We are concerned that 'safeguarding' seems to be glossed over in this Guideline – not only here but also on Page 6 Line 17 and Page 8 Line 20. The only NICE Guideline offered is in relation to domestic violence and abuse. We see no reference to guidelines or information for HCPs that would enable them to address infant maltreatment, including abusive head trauma. It goes without saying that all parental carers need to be addressed on this topic (Dias et al., 2005). The Fatherhood Institute has been commissioned by the Child Safeguarding Practice Review Panel at the Department for Education to carry out a systematic review of the literature on fathers/ men in relation to infant (up to 12 months) non-accidental deaths. The Panel has identified non-engagement by services with fathers/ mothers' partners as central to infant non-accidental death. It would seem sensible that any NICE Guideline should be in tune with the need to address this.*	Thank you for your comment. The committee agrees that infant maltreatment is an important consideration and we think this would be included within safeguarding concerns, which are covered in various different parts of the guideline (including communication between healthcare professionals, transfer of care to community care and topics to discuss at postnatal contacts). We have added a reference to the NICE guideline on child abuse and neglect in the guideline which includes a section on working with parents and carers.
Fatherhood Institute	Guideline	5	12	Our suggestion Add Recommendation: According to the woman's wishes, the baby's father/ woman's partner should be invited to be present Our rationale: Fathers are likely to be at home (more than 90% of employed fathers take time off after the birth, and post-Covid many are likely to be working from home). Fathers/ women's partners need to be well informed to support the woman and baby effectively. Acknowledgement by an	Thank you for your comment. In general, we refer to parents when talking about the care of the baby and we have added a recommendation that those with parental responsibility have the right to be involved in the care of the baby if they so choose. We hope this is clearer now. Beyond the care of the baby, involvement of the woman's partner (who may or may not have parental responsibility) should be according to her wishes. These principles apply to this

				HCP is likely to encourage positive behaviour and father-infant bonding.	specific recommendation about the first midwife visit as well and we have not stated these here separately.
Fatherhood Institute	Guideline	6	4	Our suggestion Add Recommendation According to the woman's wishes, the baby's father/ woman's partner should be invited to be present Our rationale: See previous Comment	Thank you for your comment. The recommendation about involving the woman's partner according to her wishes already covers this point. The section where the recommendation sits is now renamed 'Principles of care' and is the first section of the guideline. In this section the guideline also states that the woman's preferences should be responded to and the timing, content and delivery of information should be tailored according to the needs and preferences of the woman.
Fatherhood Institute	Guideline	6	15	Our suggestion Redraft so this reads: previous or current mental health concerns in either parent Our rationale: The father's mental health impacts on the mother's and baby's wellbeing. We can provide a review of the research if this would be useful.	Thank you for your comment. The remit of this guideline is the postnatal care for women who have given birth and their babies. We acknowledge the impact that the father's mental health may have on the family, however, this is outside the scope of this guideline.
Fatherhood Institute	Guideline	6	15	*. . . safeguarding issues (also see the NICE guideline on domestic violence and abuse). As mentioned above, we are concerned that 'safeguarding' seems to be glossed over in this Guideline. The only NICE Guideline offered is in relation to domestic violence and abuse. We see no reference to guidelines or information for HCPs that would enable them to address infant maltreatment, including abusive head trauma. It goes without saying that all parental carers need to be addressed on this topic (Dias et al., 2005).*	Thank you for your comment. We take the point and have added a cross reference to the NICE guideline on child abuse and neglect.

Postnatal Care

Consultation on draft guideline - Stakeholder comments table
16/10/2020 – 25/11/2020

Fatherhood Institute	Guideline	6	19	Our suggestion Redraft so this reads concerns that either parent has about the woman or their baby's care Our rationale Fathers/ women's partners are first responders (and potentially first informers) where the mother or baby are experiencing challenges	Thank you for your comment. The committee agrees and have revised the recommendation accordingly.
Fatherhood Institute	Guideline	7	2	Our suggestion: Amend so this reads: A woman may be supported by her baby's father, a partner, a family member or friend . . . Our rationale This is an appropriate point in the text to include the word 'father' to prompt HCPs to look at the father if he is present, given that he is by far the most likely other adult to be present.	Thank you for your comment. We have revised the wording here and added a definition of what we mean by 'partner' in the context of this guideline, including that this could be the baby's father.
Fatherhood Institute	Guideline	7	003 - 006	This Rec. is one of the few that mentions the woman's partner etc. and the only point in the Draft Guideline which instructs the HCP to ''Involve them according to the woman's wishes' The rest of the section, however, talks solely about 'the woman'. Our suggestion: Redraft to read'…the needs and preferences of the woman, and the baby's father/ her partner (if present)' Our rationale: Consistency with ''Involve them according to the woman's wishes' This is an appropriate place to include the word 'father' to prompt HCPs to look at the father if he is present, given that he is by far the most likely additional adult to be present	Thank you for your comment. The recommendation about involving the woman's partner according to her wishes already covers this point so we do not think this needs to be repeated. We have also added a recommendation about the right of those with parental responsibility to be involved in the care of the baby. We have added a definition of "parents" to the 'Terms used in this guideline' section which clearly states that this is often the mother and the father, although other family arrangements exist. The section where these recommendation sit is now renamed to 'Principles of care' and is the first section of the guideline.
Fatherhood Institute	Guideline	7	6	Our suggestion: Amend so this reads:… preferences of the woman and the baby's father/ her partner Our rationale: Consistency with ''Involve them according to	Thank you for your comment. The recommendation about involving the woman's partner according to her wishes already covers this point so we do not think

				the woman's wishes' Also, throughout this section it is easy to include the word 'father' to prompt HCPs to look at the father if he is present, given that he is by far the most likely additional adult to be present	this needs to be repeated. We have also added a recommendation about the right of those with parental responsibility to be involved in the care of the baby. We have added a definition of "parents" to the 'Terms used in this guideline' section which clearly states that this is often the mother and the father, although other family arrangements exist. The section where these recommendation sit is now renamed to 'Principles of care' and is the first section of the guideline.
Fatherhood Institute	Guideline	7	20	Our suggestion: Amend to read: Check that the woman and the baby's father/ her partner understand the information they have been given, and how it relates to them. Provide regular opportunities for them to ask questions and set aside enough time to discuss any concerns. Our rationale: Consistency with ''Involve them according to the woman's wishes' The baby's father's/ mother's partner's understanding will not only help to keep the baby safe but will also help the mother's understanding ('two hears are better than one'). An RCT of an intervention that aimed to reduce rates of abusive head trauma in infants worked well when large numbers of new fathers were successfully engaged with, alongside the baby's mother (Dias et al., 2005).	Thank you for your comment. We recognise the important role that partners play and we think the specific recommendation about involving the woman's partner according to her wishes covers this already. The focus of the guideline is providing care for the woman and her baby. We have made some revisions to the guideline to clarify that in relation to the care of the baby, we generally refer to the parents, not just the woman.
Fatherhood Institute	Guideline	7	25	Our suggestion: Amend to read: women who smoke or misuse substances or whose baby's father/ her partner smokes or misuses substances Our rationale: Consistency with ''Involve them according to the woman's	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The issues mentioned in

				wishes' Mothers' male partners are more likely to smoke/ misuse substances than the women are. Identifying the father's smoking/ substance use is as important as identifying the woman's. How can good postnatal care with home visits NOT include looking at such health behaviours in the father/ woman's partner?	your comment may well also be relevant, however, this is not covered by the above NICE guideline.
Fatherhood Institute	Guideline	7	026 - 027	Our suggestion: Amend to read: women and their partner who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English Our rationale: Consistency with ''Involve them according to the woman's wishes' Vulnerabilities of this kind in EITHER parent are significant	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The issues mentioned in your comment may well also be relevant, however, this is not covered by the above NICE guideline.
Fatherhood Institute	Guideline	8	1	Our suggestion: Amend to read: young women (under 20) or whose partner is under 20 Our rationale: Consistency with ''Involve them according to the woman's wishes' If EITHER parent is very young, the family is likely to be vulnerable (DH/RCM, 2015)	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The issues mentioned in your comment may well also be relevant, however, this is not covered by the above NICE guideline.
Fatherhood Institute	Guideline	8	2	Our suggestion: Add bullet point to read women or their partner with disabilities, who are homeless or who suffer extreme economic deprivation Our rationale: In either parent, these are all significant markers of disadvantage which are likely to impact on maternal and baby health and require additional support.	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The issues mentioned in your comment may well also be relevant, however, this is not covered by the above NICE guideline.
Fatherhood Institute	Guideline	8	8	Our suggestion: Add after 'as appropriate': According to the woman's wishes, include her baby's father/ her partner in discussions	Thank you for your comment. The focus of this guideline is on the postnatal care of the mother and the baby, however, we recognise

				or speak with them separately Our rationale: The baby's father/ woman's partner is (i) best placed to identify any emerging issues, such as depression in the mother (ii) likely to be her main source of support (iii) has substantial impact on her wellbeing – far greater, usually, than any other person, including in the wider family (iv) has shared responsibility for behaviours that will affect her wellbeing – e.g. contraception – and is as much in need of information as she is. If he is not given this information, then services are placing sole responsibility on the woman. This is burdensome and inequitable.	the importance of partners. Partners should be involved according to the woman's wishes and this is stated in the guideline.
Fatherhood Institute	Guideline	8	19	Our suggestion: Add bullet point to read partner's physical or mental health and adjustment Our rationale: There is abundant evidence, of the impact on women and infants of poor mental health in the baby's father (Philpott et al., 2020; Ramchandani et al., 2011; Tran et al., 2019) In addition, NHS England is bringing out Guidelines to prompt HCPs to engage with the baby's father/ the woman's partner where the woman has mental health vulnerabilities. NICE needs to be aware of and make recommendations in line with, this.	Thank you for your comment. The remit of this guideline is the postnatal care for women who have given birth and their babies. We acknowledge the impact that the father's mental health may have on the family, however, this is outside the scope of this guideline.
Fatherhood Institute	Guideline	8	20	*. . . safeguarding concerns, including domestic abuse (see the NICE 20 guideline on domestic violence and abuse). ********As mentioned in earlier Comments (above). we are concerned that 'safeguarding' seems to be glossed over in this Guideline. The only NICE Guideline offered is in relation to domestic violence and abuse. We see no*	Thank you for your comment. The committee agrees about the importance of this and we have added a reference to the NICE guideline on child abuse and neglect.

				reference to guidelines or information for HCPs that would enable them to address infant maltreatment, including abusive head trauma. It goes without saying that all parental carers need to be addressed on this topic (Dias et al., 2005).	
Fatherhood Institute	Guideline	9	22	Our suggestion: Redraft so this reads: At the first postnatal midwife contact, inform the woman (and, according to the woman's wishes) her partner . . . Our rationale: The baby's father/ woman's partner should be fully informed, not least because if they don't understand the dangers inherent in the symptoms, they may discourage or not encourage the woman from seeking medical help	Thank you for your comment. We have not provided this level of detail in the recommendations about how to assess the different health issues or exactly which measurements to take but we think the assessment of signs and symptoms of pre-eclampsia already covers this point.
Fatherhood Institute	Guideline	10	6	Our suggestion: Add 'and the baby's father/ her partner' so this reads At each postnatal contact, give the woman and her baby's father/ her partner the opportunity to talk about their birth experience . . . Our rationale: There is evidence that fathers also need the opportunity to de-brief, especially after a traumatic birth. If their experiences are not addressed, their mental health can be negatively affected – with implications for the wellbeing of the whole family (Elmir & Schmied, 2016).	Thank you for your comment. The focus of this guideline is the postnatal care of the women and babies and while we recognise the importance of partners'/fathers' experience and wellbeing, this is outside the remit of this guideline. However, we have made a reference to the NICE guideline on antenatal and postnatal mental health which includes a section about birth trauma and these recommendations include taking into account the effect on the partner.
Fatherhood Institute	Guideline	13	16	Our suggestion: Re-draft to read At each postnatal contact, ask all parental carers present if there are any concerns about . . Our rationale: the baby's health and safety can only benefit if all parental caregivers are offered the opportunity to share observations with the HCP.	Thank you for your comment. The committee agrees and have changed the recommendation to say "parents". We have also added a definition for the term "parents".

Postnatal Care

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Fatherhood Institute	Guideline	13	16	The transition of terminology needs to be highlighted here as the topic changes from the mother's own health/wellbeing to the baby. This can be done by spelling out the opening definition.****So: "At each postnatal contact, ask parents (mother plus her baby's father / other people who provide parental care to the baby) if there are any concerns….."	Thank you for your comment. We agree and have changed the wording to say "parents" where appropriate. We have also added a definition for the term "parents".
Fatherhood Institute	Guideline	15	7	Our suggestion: Amend to read: Give all parental carers present information about . . . ur rationale: It was right at the beginning of the Draft Guideline that you defined 'parents' to include mother, father and other main caregivers. If this is not re-stated, practitioners are likely to 'hear' the term 'parents' as the plural of mothers Once this wider definition is re-iterated, you can mainly just use the term 'parents' in the rest of the Draft Guideline Using 'mothers' and 'fathers' in the plural covers same sex households.	Thank you for your comment. We have kept "parents" and defined the term clearly in the guideline so not to be confusing.
Fatherhood Institute	Guideline	16	009 - 013	Our suggestion: Amend so that you are clear that you are talking about both parents. Strongly advise parents not to share a bed with their baby if either of them: • has had 2 or more units of alcohol • is a smoker • has taken medicine that causes drowsiness • has taken recreational drugs Our rationale: The Lullaby Trust https://www.lullabytrust.org.uk/safer-sleep-advice/co-sleeping/ makes clear that the above apply to either the woman or her partner. And the Child Safeguarding	Thank you for this suggestion, with which the committee agree. In the final version of the guideline, this recommendation now states "either parent".

				Practice Review Panel's recent review points to safe sleeping being compromised by 'a lack of information about the infant's father or mother's current partner, particularly if there was a failure to disclose this information' (p.30) (Child Safeguarding Practice Review Panel, 2020)	
Fatherhood Institute	Guideline	17	002 - 003	Our suggestion: Amend so that the importance of father-infant bonding is made clear. . . . discuss the importance of bonding and emotional attachment with fathers as well as mothers Our rationale: Same sex parents will not be offended if you use the terms 'fathers' and 'mothers': they regard themselves as two fathers or two mothers (ii) There is abundant evidence, some of which we have identified in earlier Comments that infants form multiple attachments, that the security of each is central to infant/ child/ adult wellbeing, and that security of attachment in either parent can be impacted by the behaviour of the other. All parents need to understand this.	Thank you for your comment. We use the term "parents" in this recommendation. We have added a definition of what "parents" in this guideline so it should be clear that this also includes the father (if relevant).
Fatherhood Institute	Guideline	17	003 - 018	Guideline Recommendations 1.3.14, 1.3.15, 1.3.16, 1.3.17) refer to 'parents' throughout this section. Is this intentional? If so, then other wording in this section will need to be changed (see previous Comments). Or is the word 'parents' being used as the plural of 'mother' here?	Thank you for this comment. "Parents" is used in this section intentionally as these relate to all/both parents. The term "parents" has been defined in the Terms used in this guideline so it should be clear what it means.
Fatherhood Institute	Guideline	17	12	Our suggestion: Add bullet point to read: the father's wellbeing and adjustment Our rationale: The father's wellbeing and adjustment have direct and indirect impacts	Thank you for your comment. The committee agrees that this can be a relevant issue, however, the list is not attempting to be exhaustive but point to some of the most

				on the baby's wellbeing and adjustment – AND THEIR PHYSICAL SAFETY (see abundant safeguarding literature that we can provide if asked)	common types of challenges in the postnatal period. Demands of parenthood, for example, could encompass the issue you mention.
Fatherhood Institute	Guideline	19	027 – 028	How has it come to pass that fathers (and other parental caregivers) have virtually disappeared from the 2020 Draft Guideline? The reason becomes clear when we read in Evidence Review O that it cannot update the recommendation in the 2006 NICE postnatal guideline that 'Healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit." [2006] because it has 'excluded any evidence on fathers': 'Note that the committee will not be able to update recommendation 1.4.9 (which will be stood down together with all recommendations from the 2006 version of CG37) because father-child attachment is excluded from this review question.'	Thank you for your comment. We have used the term 'parents' in various parts of the guideline and have added a definition of the term in the Terms used in this guideline section which makes it clear that this means the main caregivers of the baby, often the mother and the father. In terms of the review on emotional attachment. The committee looked for evidence on mother-infant attachment, however, decided to extrapolate to cover all/both parents in the recommendations.
Fatherhood Institute	Guideline	20	9	*be respectful of parents' choices Our question: Is the Guideline using 'parents' as a synonym with 'mothers' here – i.e. does it mean 'mothers' choices – or is the term 'parents' being used intentionally to suggest that the t the choice should be made by both parents – which is what the use of the term 'parents means? It would be perfectly appropriate to say 'mothers" here*	Thank you for your comment. Parents have been defined in the guideline as anyone who has main responsibility for the care of a baby. This will often be the mother and the father, but many other family arrangements exist. The choice about feeding is generally the mother's, however, both parents might have concerns and take part in the discussions around feeding.
Fatherhood Institute	Guideline	20	11	Our suggestion: Amend to read Before and after the birth, discuss breastfeeding with both parents if present and … Our rationale: While whether or not to breastfeed is the mother's decision, a wealth of evidence	Thank you for your comment. We have not specified this in the recommendation because we do not think it is needed. The guideline already states that partners should be involved according to the woman's wishes

				which we can provide if asked, reveal fathers' influence. Fathers who are not well-informed cannot influence the mother in the most positive way – see also Comments below.	and if they are present and the woman wishes to involve them, the discussion should then involve both parents (if there are two).
Fatherhood Institute	Guideline	21	3	Add: advice about other ways the baby's father and other parental carers can comfort and soothe babies. Our rationale: The Draft Guideline includes this in the section on bottle-feeding on page 25. We do not understand why it is not included here unless it is the Guideline's intention that women who breastfeed should be solely responsible for comforting and soothing the baby	Thank you for your comment. The line this comment is referring is to is about the potential benefits of breastfeeding. The next recommendations says to provide information to partners about how to comfort and bond with their baby so we think this is issue is covered.
Fatherhood Institute	Guideline	21	005 - 006	Add the benefits of breastfeeding from the section above (information about breastfeeding for women) to information for partners. The partner's section should include: nutritional benefits for baby health benefits for both the baby and the woman how it can have benefits even if only done for a short while how it can soothe and comfort the baby Our rationale An RCT that achieved substantially higher breastfeeding fates included information for fathers on "Why breast is best" (Pisacane et al., 2005). Fathers' need for information about the benefits of breastfeeding has also been identified elsewhere – e.g. in qualitative research (Sherriff, 2011) An RCT of an intervention engaging expectant fathers in reflection/ information sessions not only found reduced parenting stress in the fathers postnatally, but also better breastfeeding rates (initiation and maintenance) and	Thank you for your comment. We think partners will be involved in these discussions if the woman wishes to involve them therefore, this has not been separately stated here. The recommendation above also states that information to partners should include ways how to comfort and bond with the baby so we think this is covered.

				positive reports by mothers of support from their partner (Tohotoa, 2012; Tohotoa et al., 2011) Also add: advice about other ways the baby's father and other parental caregivers can comfort and soothe babies. Our rationale: The Draft Guideline includes this in the section on bottle-feeding on page 25. We do not understand why it is not included here unless it is the Guideline's intention that mothers who breastfeed should be solely responsible for comforting and soothing the baby.	
Fatherhood Institute	Guideline	21	10	Our suggestion: Re-draft to read: Inform parents that, under the Equality Act 2010, women have the right to breastfeed in any public space Our rationale: Fathers can be advocates for their partner, including of her right to breastfeed in public spaces. However, many fathers are embarrassed at the idea of their partner doing so (Henderson et al., 2011). Engaging them on this topic alongside the mother is vital.	Thank you for your comment. We have changed this to "woman and their partners".
Fatherhood Institute	Guideline	23	10	Our suggestion: Re-draft to read: Provide information, advice and reassurance about breastfeeding, so women and their partner know what to expect and when and how to seek help. Our rationale: An RCT that achieved substantially higher breastfeeding fates practical instruction including on infant positioning, latching, managing sore and inverted nipples, mastitis etc. (Pisacane et al., 2005). Another RCT found paternal breastfeeding self-efficacy key to improving breastfeeding rates (Abbass-Dick et al., 2015).	Thank you for your comment. We have added "women (and their partners)" to the recommendation.

Fatherhood Institute	Guideline	24	6	Our suggestion: Re-draft to read: Any concerns the woman, or her partner if present, have about . . . Our rationale: As outlined in our other Comments, the more the partner understands, the better	Thank you for your comment. We have changed this to "parents".
Fatherhood Institute	Guideline	25	2	*Before and after the birth, discuss formula feeding with parents who are considering or need to formula feed. Our question: Is the Draft Guideline using 'parents' as a synonym with 'mothers' here? Or is it intended that the discussion should be with both parents? We think 'parents' is appropriate here.*	Thank you for your comment. "Parents" has been defined in the terms used and mean anyone who have the main responsibility for the baby, usually mother and the father but other family arrangements exist. We have purposefully used the word "parents" here.
Fatherhood Institute	Guideline	25	13	*For parents who formula feed have a one-to-one discussion about safe formula feeding Our question: The Guideline uses the term 'parents' (plural) but then instructs the HCP to have a 'one-to-one' discussion about formula feeding. If it is intended that this discussion should only be with the mother, change to 'For mothers who formula feed'. If the intention is that the discussion be with both parents (which would seem sensible), leave 'parents' and then remove 'one-to-one' and perhaps change to 'face-to-face'.*	Thank you for your comment. "One-to-one" should not be taken to mean literally one person to one person but meaning that these are individualised discussions and not for example in a group setting. Face-to-face has a different meaning and that means being in the same space a not providing support remotely via phone or video calls. We have not changed the wording here.
Fatherhood Institute	Guideline	26	6	Our suggestion: Re-draft to read: advice about other ways the baby's father and other parental carers can comfort and soothe babies.Our rationale: Perhaps include the terms 'father' and 'other parental carers' again here to make clear that all caregivers are to be included in this: it's quite far back in the Draft Guideline that there has been a reminder that 'parents' includes the father and other major caregivers.	Thank you for your comment. We have revised this recommendation because it was potentially misleading. We no longer address specifically partners or family members because this applies to everyone formula feeding the baby. Feeding is sometimes used to comfort and soothe the baby and for formula fed babies this may lead to overfeeding, therefore, we recommend giving advice to parents on other ways than

					feeding which may comfort and soothe the baby.
Fatherhood Institute	Guideline	27	004 - 009	Note: the same SINGULAR v. PLURAL issues are in the Draft Guideline definitions, repeated from Evidence review O - see previous Comment	Thank you for your comment. We have revised the text and now say "parent" instead, hopefully it has improved.
Fatherhood Institute	Guideline	27	005 - 006	BONDING Your expert's definition of 'bonding' is: Bonding is the positive emotional and psychological connection that the primary carer(s), usually the mother, develops with the baby. Our suggestion – simpler more accurate – is: Bonding is the positive emotional and psychological connection that parental carers develop with a baby.	Thank you for your comment. We have revised the wording to say "parents".
Fatherhood Institute	Guideline	27	007 - 013	ATTACHMENT Your expert's definition of attachment is: "Attachment is a type of innate behaviour in children. It is the earliest relationship that a child develops with their primary carer(s). Our suggestions and rationale: We would challenge this. Attachment is neither a behaviour nor a relationship. Our preferred definition/ explanation (below) was written by Emeritus Professor Michael Lamb, former Head of the Department of Social and Developmental Psychology at the University of Cambridge and Senior Research Scientist and Chief of the Section on Social and Emotional Development at the National Institute of Child Health and Human Development, USA	Thank you for your comment. We have revised the definition of attachment partly based on your suggestion but we have tried to keep it short and avoided using complicated words or concepts. For example, we have revised to make it clear that babies form attachments with various people but the most important ones are usually with the mother and/or the father.

				'"Attachment" was first described by John Bowlby in the early 1950s. He proposed that infants are biologically predisposed to emit signals, such as cries and smiles, to which adults are biologically predisposed to respond. When adults respond promptly and appropriately to the infant's signals, the infant comes to perceive them as predictable or reliable, and secure adult-infant attachment is the result. Mother-infant and father-infant attachments do not compete with each other – they develop in parallel and on similar schedules. Infants are predisposed biologically to enjoy multiple attachments.' (see www.fatherhood.global – the Science of Fatherhood). The Evidence reviews should consider many of the articles on this site – all written by world experts. These include articles on the neurobiological changes experienced by new fathers, particularly those who engage in high levels of infant care. The Draft Guideline could add to Lamb definition of 'attachment' a slightly amended sentence from your expert's definition:: 'Early secure attachments help individuals form positive relationships with others in the future'.	
Fatherhood Institute	Guideline	28	22	RESPONSIVE FEEDING Responsive feeding is not something that only mothers do - and is equally applicable to breast and	Thank you for your comment. The committee agrees and have revised the text to say "or parent in the case of bottle feeding".

				bottle feeding.We suggest changing the word 'mother' to 'caregiver'.	
Fatherhood Institute	Guideline	General	General	In perinatal practice, and therefore in research, fathers/ women's partners are an 'under-served group' (NIHR definition - https://www.nihr.ac.uk/documents/improving-inclusion-of-under-served-groups-in-clinical-research-guidance-from-include-project/25435 Health interventions cannot be judged successful until they have been tested with under-served, as well as well-served groups. Unless fathers/ women's partners – probably the most important under-served group in the postnatal period - are systematically engaged by healthcare practitioners, they will continue to be under-served in health research (Macfadyen et al., 2011); and the effectiveness of interventions, including those designed for mothers, will be undermined (Rowe et al., 2017).	Thank you for your comment. The scope for this guideline describes the 'groups that will be covered' as women and babies from birth to 8 weeks, which explains the focus of the majority of recommendations. That said, in response to yours and a number of other stakeholder comments, the committee agreed to edit certain recommendations so they now also refer to partners or to 'parents' rather than just mothers. These changes were made in particular to recommendations about the care of the baby and decisions about such issues as feeding.
Fatherhood Institute	Guideline	General	General	Failure to include the word 'father' in the Draft Guideline (or any of the related documents) It is widely recognised that the term 'father' needs to be included in policy and practice guidelines if practitioners are to engage with anyone other than the mother (Brandon et al., 2014; Clapton, 2014; Hart, 2011). Practice with families is traditionally so mother-focused that using the term 'parents' is not, ultimately, inclusive:	Thank you for your comment. The scope for this guideline describes the 'groups that will be covered' as women and babies from birth to 8 weeks, which explains the focus of the majority of recommendations. That said, in response to yours and a number of other stakeholder comments, the committee agreed to edit certain recommendations so they now also refer to partners or to 'parents' rather than just mothers. To avoid confusion

				practitioners ‘hear’ ‘parent’ as ‘mother’, and indeed, as pointed out in this very Draft Guideline, it is often used that way. ‘Partner’ is not always a substitute because it refers to the connection between the woman and the other adult, not the relationship between the father and child. In postnatal care, ‘father’ should be included for the following reasons: (i) Fathers are THERE: 95% of couples in England & Wales jointly register the birth of their baby (ONS, 2020) 95% of biological parents are married, cohabiting or (sometimes temporarily) living separately but planning to raise their child together (Kiernan & Smith, 2003) it is almost unheard of for a woman to have a male partner who is not her baby’s biological father at the time of the birth (ONS, 2014) only 1:1000 births in England & Wales is registered to two women (ONS, 2016) (ii) Engaging directly with the father, according to the woman’s wishes, is likely to deliver the following benefits: the father’s knowledge of issues facing his family should contribute positively to assessment and support vulnerabilities in the father can be identified, and suitable referrals made the father’s strengths can be identified, and drawn on to support mother and baby the father’s knowledge and understanding can be enhanced, enabling him to engage more sensitively with his baby and to better support his baby’s mother In order to be inclusive of ‘second parents’ who are not the baby’s fathers, the terms ‘father/ other caregiver(s)’ or ‘father/ partner’ can be used.	"partner" and "parents" have also been defined in the ’Terms used in this guideline’ section.

				Same-sex couples refer to themselves as two mothers or two fathers, and therefore do not take exception to the terms ‘mothers’ and ‘‘fathers’. In our detailed Comments (below) on this Draft Guideline, we indicate points in the text at which the term ‘father’ or ‘father/ woman’s partner’ can be usefully included, so that HCPs will keep them in mind.	
Fatherhood Institute	Guideline	General	General	Other NICE Guidelines, such as the Nice Guideline on Pregnancy and Complex Social Factors, have sections on Training for healthcare staff If fathers/ women’s partners are to be included in this Postnatal Care Guideline, there should be fairly simple training provided to help HCPs to feel comfortable engaging with fathers’/ women’ partners; and to understand the potential benefits of doing so – and possible costs of not addressing/ including them. The Fatherhood Institute has worked extensively with HCPs, including thousands of Health Visitors.	Thank you for your suggestion. The development of this guideline did not include a review question about training for health care professionals so it would be beyond the scope of the guideline to make these recommendations. That said, while finalising the guideline, the committee did take care to place a greater emphasis on the role of both parents, particularly in relation to decisions about the care of the baby and in relation to bonding and emotional attachment.
Fatherhood Institute	Scope	001 - 003	General	Draft Guideline objectives are not supported by evidence included in the Guideline Scope: Draft Guideline Objectives p. 1. “This guideline is needed . . . to provide women and their partners (especially first-time parents) with information and support’ p.3 ‘This guideline is for: . . . people who look after babies in the first 8 weeks after birth, for example, parents and carers Guideline Scope The only subsequent references to ‘partners’ in the Guideline Scope (there are no references to parents or other carers) are in relation to infant feeding (p.12-13)	Thank you for your comment. The final version of the scope does not state on page 1 that "this guideline is needed…" but you are right to highlight that on page 3, there is a statement about the audience for the guideline ("people who look after babies in the first 8 weeks..."). To clarify, this means that the guideline will be useful for those people; it does not mean those people are the focus of the guideline. Instead, the guideline covers "Women and babies from the birth of the baby until the end of the postnatal period..." This explains the focus of

					the majority of recommendations. That said, while finalising the guideline, the committee did take care to place a greater emphasis on the role of both parents, particularly in relation to decisions about the care of the baby and in relation to bonding and emotional attachment.
Fatherhood Institute	Scope	22	Para 3.6 (Maternal & baby outcomes)	Fathers' impacts on maternal/ baby outcomes are not recognised or addressed – nor is the impact on the fathers of the births of their babies. Evidence relating to their influence was not included in the Guideline Scope and Evidence reviews. Central to maternal and baby outcomes are (i) the behaviours/ strengths/ vulnerabilities of father/ partner and their capacity to support the mother and engage positively with the baby; and (ii) father/ partner engagement by services (impacting on maternal and baby outcomes)	Thank you for your comment. The scope for this guideline describes the 'groups that will be covered' as women and babies from birth to 8 weeks, which explains the focus of the evidence reviews and the majority of recommendations. That said, in response to yours and a number of other stakeholder comments, the committee agreed to edit certain recommendations so they now also refer to partners or to 'parents' rather than just mothers. To avoid confusion "partner" and "parents" have also been defined in the 'Terms used in this guideline' section.
Fatherhood Institute	Scope	22	Para 3.6 (Maternal outcomes)	We think there is a significant drafting error here – viz: Maternal outcomes: 1 maternal mortality 2 maternal morbidity 3 parental quality of life 4 service user experience 5 parental ability to carry out activities of daily living 6 parental emotional attachment We think that here 'parental' should read 'maternal' because at no point in the Guideline scope (or in the Draft Guideline) is attention paid to anyone other than the mother's quality of life, ability to carry out activities of daily living, or emotional attachment. It is common, in careless drafting, for the terms 'parent/ parental' to be used as synonyms for 'mother/ maternal'	Thank you for highlighting this. In finalising the guideline, the committee edited certain recommendations so that where appropriate, they now also refer to partners or to 'parents' rather than just mothers. To avoid confusion "partner" and "parents" have also been defined in the 'Terms used in this guideline' section.

				(Brandon et al., 2014; Clapton, 2014; Hart, 2011). We have identified a number of occasions in the Draft Guideline where we think 'parent/ parents' are being used to mean 'mother/ mothers' – resulting in confusion. We have pointed these out in specific Comments, below	
Fatherhood Institute	Scope	General	General	Inadequate NICE response to the scope consultation in finalising the Guideline Scope – thus constraining the research questions and specified outcomes for the evidence reviews Stakeholders, including Public Health England, the National Childbirth Trust and Birthright, who commented on the draft scope https://www.nice.org.uk/guidance/gid-ng10070/documents/consultation-comments-and-responses-2 recommended that fathers/ partners be included within the inclusion criteria/ specified outcomes for evidence reviews in relation to attachment/ bonding, skin-to-skin and mental health/ wellbeing. In responding to that feedback, NICE implied that they would be included, but the Guideline Scope did not do so.	Thank you for your comment. The committee acknowledge your point and agree that father/ partner's outcomes could have been included in the protocol for the emotional attachment review. However they made the decision during protocol development to focus on interventions that promote emotional attachment between mother and baby. This reflects the scope of the guideline being 'women and babies' but is not intended to undermine the importance of emotional attachment between the baby and other primary carers, namely fathers or partners. In fact the recommendations that were drafted on the basis of this evidence review are not at all focused on promoting attachment between mothers and babies only. The committee used their experiential knowledge about the importance of attachment with both parents to make recommendations emphasising the role and importance of "parents" (not simply 'mothers').
GP Infant Feeding Network	Guideline	7	023 - 027	This section on women who need additional support is important but is somewhat inconspicuous in this position. The NICE guideline on pregnancy and complex social factors CG110 also has relevance to previous sections 1.1.3 (First Midwife visit)	Thank you for your comment. The committee agrees that the issues covered by the NICE guideline on pregnancy and complex social factors relate to various aspects of antenatal care. We have re-ordered the sections so that the section in which this reference is

				and 1.1.4 (First Health Visitor visit)- could it also be included as a link in these sections, or mentioned earlier in the recommendations?	made now comes first (renamed as 'Principles of care'). We hope that this improves the prominence of this reference.
GP Infant Feeding Network	Guideline	8	005 - 021	Include a topic of discussion in the Assessment and care of the woman: persistent postnatal pelvic girdle pain	Thank you for your comment. Potential physical problems (included as a discussion point in the recommendation) would include pelvic girdle pain. Pain is also included in the recommendation about assessing the woman's health.
GP Infant Feeding Network	Guideline	10	5	Could another bullet point be added here to highlight the importance of seeking medical review if symptoms/signs of mastitis persist for more than 24 hours despite self-management, or 48 hours after taking antibiotics? Breast abscess has been a cause of death in a previous MBRRACE report on maternal mortality (see p29 of the link: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/Saving%20Lives%20Improving%20Mothers%20Care%20report%202014%20Full.pdf)********	Thank you for your comment. The committee discussed your suggestion and agreed to add new bullet points recommending that the woman should be informed about the need for further medical advice if there are worsening signs or symptoms which could indicate mastitis and if the woman has symptoms or signs of potentially serious conditions that do not respond to treatment.
GP Infant Feeding Network	Guideline	13	009 - 010	Question 3: Anecdotally we hear very mixed reports about the analgesia given to breastfeeding women for perineal and wound pain. Some are denied adequate analgesia due to misconceptions regarding options. Many prescribers are not familiar with resources to support prescribing in lactation (as recommended in NICE PH11, recommendation 15). This bullet point could be an opportunity to reference The UK Drugs	Thank you for this information. The committee discussed your suggestion and although they didn't amend that specific recommendation, they did add to another recommendation to ensure that healthcare professionals know about safe medicine use and prescribing for breast feeding women.

				in Lactation Advisory Service (UKDILAS) and factsheets on analgesia e.g. https://www.sps.nhs.uk/articles/which-weak-opioids-can-be-used-during-breastfeeding/ or the Royal College of Obstetrics and Gynaecology guidance https://www.rcog.org.uk/en/guidelines-research-services/guidelines/sip59	
GP Infant Feeding Network	Guideline	14	001 - 003	This update combines the checklist for the 72-hour baby examination with the 6-8 week checklist. We note that recommendation 1.4.13 from the previous version of NICE CG37 (social smile and visual fixing and following at the 6-8 week check) has no longer been included, although social smile remains part of the Red Book check list.	Thank you for your comment. This was an omission and we have now added this recommendation.
GP Infant Feeding Network	Guideline	14	025 - 027	With regards to plotting infant weight on the growth chart- errors are sometimes made if appropriate adjustment for significant prematurity is not considered. Could an additional brief point be made about this?	Thank you for your comment. Babies born preterm are outside the scope of this guideline.
GP Infant Feeding Network	Guideline	15	021 - 023	Question 1: This recommendation will be challenging in practice as we suspect that many doctors are not familiar with the Baby Check scoring system. An awareness campaign or education for GPs and other health care professionals may be required to implement this recommendation.	Thank you for your comment. Baby Check is a simple tool to use so we do not expect it requires extensive training although we recognise it may not be widely known or used by healthcare professionals in current practice.
GP Infant Feeding Network	Guideline	18	005 - 010	Question 1: This recommendation will be challenging in practice as we suspect that many doctors are not familiar with the Baby Check scoring system. An awareness campaign or education for GPs and other health care professionals may be required to implement this recommendation. We would	Thank you for your comment. Baby Check is a simple tool to use so we do not expect it requiring extensive training although we recognise it may not be widely known or used by healthcare professionals in current practice. The Baby Check covers a wide range of symptoms and signs, including what

				have concerns that if the scoring system was not fully understood its use might distract clinicians from asking about other significant red flags which do not feature in Baby Check.	would be considered as 'red flags', however, the recommendation specifically states that it could be used to supplement clinical assessment, i.e. clinical assessment should not be solely based on it.
GP Infant Feeding Network	Guideline	19	014 - 026	Could we suggest that 'faltering growth' is added as a further bullet point in this section on serious illness in young babies, especially as a >10% weight loss in the early days may indicate dehydration or an illness (e.g. UTI, cardiac causes) and requires assessment and potentially Paediatric referral. NICE NG75 (Faltering Growth) could be linked here.	Thank you for your comment. The committee agrees that faltering growth can be a serious issue and have added a reference to the NICE guideline on faltering growth in a separate recommendation in this section. However we have not added it to this recommendation as the guidelines listed here are the sources for the red flags listed and the faltering growth guideline does not list such red flags.
GP Infant Feeding Network	Guideline	20	10	'Breastfeeding support' is commonly misunderstood and may be interpreted as 'encouragement' rather than skilled assessment and the development of a management plan. Could 'breastfeeding support' be defined in the glossary of terms (p27-28)?	Thank you for your comment. The committee agreed with the point you make but they felt it was best addressed by signposting with a hyperlink from this section to the recommendations on supporting women to breastfeed within this guideline. By doing so they felt this would explain exactly what is meant by breastfeeding support.
GP Infant Feeding Network	Guideline	21	008 - 009	Question 1: This recommendation may require awareness raising amongst GPs, Health Visitors and parents.	Thank you for your comment. The issue of vitamin D supplementation is not covered by this guideline. However the NICE guideline on vitamin D includes a section about raising awareness among healthcare professionals.
GP Infant Feeding Network	Guideline	21	012 - 019	Question 1: GPs and other doctors looking after postnatal women may not be familiar with these points as the basics of supporting breastfeeding listed here do not consistently feature in medical education/medical curricula yet. The World Breastfeeding Trends Initiative (WBTi) UK Report from	Thank you for your comment. The competencies and training of healthcare professionals are outside the remit of this guideline, although we do list some issues that healthcare professionals caring for women and babies in the postnatal period should have around breastfeeding. The

				2016 details gaps in UK health professional training with regards to optimal infant and young child feeding and makes recommendations (Indicator 5, p28-35 https://ukbreastfeedingtrends.files.wordpress.com/2017/03/wbti-uk-report-2016-part-1-14-2-17.pdf). Biggs et al (2020) recently surveyed UK undergraduate medical schools and students and concluded that improvements in training for doctors was needed: https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-020-00290-z If unfamiliar with managing breastfeeding related issues doctors would need to signpost or refer on to colleagues. Recently learning objectives for doctors have been suggested by The Baby Friendly Initiative (https://www.unicef.org.uk/babyfriendly/accreditation/universities/learning-outcomes/learning-outcomes-medical-students/).	UNICEF Baby Friendly Initiative resources may be useful, although because they have not been accredited by NICE, we have not made direct references to them in the recommendations.
GP Infant Feeding Network	Guideline	21	012 - 019	Question 3: Could the NICE CKS Breastfeeding Problems topic be linked here to support clinicians? (https://cks.nice.org.uk/topics/breastfeeding-problems/)	Thank you for your comment. The way that the NICE CKS guidance are developed differs from the clinical guidelines that NICE produces. For example, the CKS guidelines are summarising the NICE clinical guidelines (among other resources) as the basis. NICE guidelines therefore do not usually refer back to the CKS guidance.
GP Infant Feeding Network	Guideline	23	023 - 024	Question 3: Could the NICE CKS Breastfeeding Problems topic be linked here to support clinicians?	Thank you for your comment. The way that the NICE CKS guidance are developed differs from the clinical guidelines that NICE produces. For example, the CKS guidelines

				(https://cks.nice.org.uk/topics/breastfeeding-problems/)	are summarising the NICE clinical guidelines (among other resources) as the basis. NICE guidelines therefore do not usually refer back to the CKS guidance.
GP Infant Feeding Network	Guideline	26	010 - 025	Question 3: A summary resource covering all the issues in this section would help prescribers, as many will be unfamiliar with prescribing medication for lactation suppression. Clear communication between hospital and GP could help identify the situations when pharmacological lactation suppression is recommended. Many prescribers may also not be familiar with milk donation and how to connect mothers to their local milk bank. The following links may be helpful for prescribers: *https://www.sps.nhs.uk/articles/safety-in-lactation-bromocriptine-and-other-dopaminergic-drugs/ https://www.sps.nhs.uk/articles/safety-in-lactation-dopaminergic-drugs-used-in-parkinsons-disease/ https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005937.pub3/full *https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_55.pdf http://www.ukamb.org/donate-milk/	Thank you for your 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
GP Infant Feeding Network	Guideline	37	022 - 026	Question 1: With the implementation of the updated guidance there may be an increase in identification of problems and a need to make more referrals. Clear pathways in localities would need to be put in place to ensure referrals are dealt with appropriately and in a timely fashion. Recent investment into perinatal mental health specialist	Thank you for your comment. The committee agrees that these may be some of the challenges that local service providers have.

				services means that perinatal mental health advice can now be accessed more readily, but specialist advice on the management of perineal/pelvic floor and infant feeding problems is often more difficult to obtain promptly. Localities will need to ensure they have clear clinical pathways for advice and referral and that Midwives, Health Visitors and GPs are made aware of these.	
GP Infant Feeding Network	Guideline	48	004 - 009	Question 1: Could 'breastfeeding support' be defined in the glossary of terms as there could be confusion between the meaning of 'extra interventions', 'peer support' and 'standard postnatal contacts' (see also p23 lines 2-4, section 1.5.11). This could have implications with regards to commissioning.	Thank you for your comment. Instead of defining what is meant by breastfeeding support, we have added a cross-reference to the "supporting women to breastfeed" section into the recommendation you're commenting on. The elements of the breastfeeding support recommended in this guideline are described in that section.
GP Infant Feeding Network	Guideline	General	General	Question 4: The COVID-19 pandemic has had implications on access to routine baby weighing clinics in some localities.	Thank you for sharing this information. This will not have implications to the guideline but it is important to know.
GP Infant Feeding Network	Guideline	General	General	We commend the Committee on the guideline update and the supportive recommendations for care of both breastfeeding and formula feeding families.	Thank you.
GP Infant Feeding Network	Guideline	General	General	As the guideline is extremely comprehensive and cross-links a number of other NICE guidelines, it would be very helpful if the digital format ultimately published is user-friendly for clinicians. For example: use of bullet points, use of boxed sections, avoid large chunks of the text being hyperlinked successively etc.	Thank you for your comment. We hope that the web version of the guideline will be more user friendly than the PDF version which was out for consultation. The web version is more interactive and allows to for example to see the justification for the recommendation directly underneath the recommendations.
GP Infant Feeding Network	Guideline	General	General	Pelvic girdle pain (PGP) can be a severe condition, affecting around one in five pregnant women. PGP can cause severe	Thank you for your comment. We recognise the importance of pelvic girdle pain which affects particularly pregnant women but

				pain, physical immobility and impact a woman's mental health during pregnancy and postnatally. While for some women PGP can stop after the baby is born, for others the pain can continue postnatally and requires manual therapy to treat the joint dysfunction. We welcome the review of this postnatal guideline and encourage the committee to consider broadening post-birth checks to include discussion about pelvic pain, especially PGP. Intervening postnatally and referring women to manual therapy would limit their pain and significantly improve mental health outcomes at a time when women are already vulnerable, physically and emotionally.	sometimes also women postnatally. We have not made a specific statement on this, however, because we think this would be captured by the assessment we recommend to be done, including asking about pain. We have also recommended that referrals should be made if there are any concerns about the woman's health.
Group B Strep Support	Guideline	General	General	Group B Strep infection is a concern for both the young baby and for the mother and therefore should be directly referred to in any postnatal care guideline, with information both about the risk factors, and the signs of GBS infection and what action to take.	Thank you for your comment. Group B streptococcal infection is outside the scope of this guideline, however, it is covered by the guideline on neonatal infection which is currently being developed by NICE and is expected to publish around the same time as the postnatal care guideline in April 2021.
Group B Strep Support	Guideline	General	General	It is also disappointing to see no mention of the need to communicate any GBS history in the mother or baby between health professionals at transfer of care or between the health professionals and the women. Most GBS infection presents in a baby's first 48 hours of life, so both parents and health professionals knowing the key risk factors, key signs and what action to take to escalate is important in ensuring sick babies are treated promptly and appropriately. Early treatment saves lives.	Thank you for your comment. This should be captured in the issues that relate to pregnancy, birth and any complications and the problems related to previous pregnancies that may be relevant to current care. Furthermore, we have covered issues relating to identifying problems in the baby's health in other sections of the guideline.

Infant Feeding Alliance	Guideline	4	1	We question whether infant feeding guidelines are in line with the principles of shared decision making and making informed decisions. All families are not being given all information on different feeding methods. Your own evidence review (T) showed that women want information on formula feeding antenatally, but the committee disregarded this, concluding that it was 'not feasible' to give all women information on formula. Another evidence review (S) showed that women 'appreciated the flexibility of mixed feeding', but there is no guidance relating to it here. Indeed, the feeding guidelines are divided into 'Breastfeeding' and 'Formula Feeding', which doesn't represent the lived reality of most families in the UK, who do both or switch at some stage. While the guidelines touch on some breastfeeding complications, parents are not being told how common these are or how severe they can be. A recent review of the literature, which sought to quantify the health effects of different infant feeding methods, calculated that for every 71 exclusively breastfed babies, one is readmitted to hospital in the first month of life, primarily due to dehydration, failure to thrive, excessive weight loss or hyperbilirubinemia (Wilson and Wilson, 2018). They also calculated that for every 13 exclusively breastfed babies, one loses greater than 10% of their birthweight. While it is unclear how these numbers needed to harm calculations apply in the UK context,	Thank you for your comment. The committee made some revisions to the feeding recommendations based on your and other stakeholders' comments. However, the recommendation remains that in the antenatal period, information is given about formula feeding to anyone who considers it. The committee recognises that women do not always decide during pregnancy how they will feed their baby so many women would likely consider the option of formula feeding and these women would get information about it. The committee agrees that the draft guideline did not acknowledge mixed feeding clearly enough so in the revisions we have tried to make this clearer. The committee did not review evidence on the prevalence of different complications, including breastfeeding complications and therefore the guideline does not go into such detail. However, we have made specific recommendations about assessing breastfeeding and assessing the health and wellbeing of the baby so that any potential complications can be avoided or identified early. We recognise that there are various private infant feeding services, however, this guideline does not make recommendations about services offered in the commercial sector. Reviewing the benefits and harms of different feeding methods was not in the scope of this guideline and thus evidence on this has not been presented. However, for the economic modelling on the cost effectiveness of breastfeeding interventions,

				we know that infant readmissions for feeding complications and jaundice more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017). Parents are told none of this. Parents are not being told that, as your research uncovered (Evidence Reviews P, Q, R, S), there is scarce evidence for what interventions work to resolve breastfeeding problems and so there may be no solution to their problem. On the contrary, we were told that if we got the right support we would be able to breastfeed. This led some of us to spend money on lactation consultants (often midwives or health visitors who also hold NHS roles), only to be advised to see cranial osteopaths, have tongue-ties cut privately or have repeat visits with the lactation consultant without effect. There is a considerable industry happy to take parents' money to provide 'breastfeeding support'. Our healthcare professionals have a duty to inform us about the evidence base for any recommended supports they give and a realistic appraisal about the likelihood of their effectiveness and what risks they might involve. Finally, parents are told about the benefits of breastfeeding without a true picture of the state of the evidence. They are not told that many of these benefits draw from correlational studies rather than experimental research, which can establish causal relationships between health-related behaviours (i.e., infant feeding method) and health outcome. We would like to see figures for absolute benefits and risks of each	a systematic review of studies that modelled long-term clinical benefits to mother and babies (and/or related cost-savings to health and personal social services) associated with breastfeeding was undertaken. The identified literature included the 2016 paper by Victoria et al. on the association between breastfeeding and various clinical outcomes (see Evidence review P for more details). The committee agrees with you about encouraging open and frank discussions about infant feeding. In the recommendations we have tried to highlight that discussions should be individualised, respectful and compassionate and take into considerations the differing needs and circumstances of the families.

				feeding method (only where there is evidence of a causal relationship) and an honest appraisal of the uncertainties in the current literature. We would also like to encourage open and frank discussion about the ways that families navigate feeding babies, including sharing feeding responsibilities between parents and with other family members. This may be particularly pertinent where sleep deprivation is a particular risk (i.e., for parents with a vulnerability to mental illness).	
Infant Feeding Alliance	Guideline	4	13	We point the committee to the fact that infant readmissions for jaundice and feeding complications more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017). Many of our babies were readmitted for complications from underfeeding after we were encouraged and supported to persist at exclusive breastfeeding in hospitals practicing the Baby Friendly protocol. We question whether the safeguards in these guidelines, such as observation of 'at least one effective feed', are enough to prevent babies suffering unnecessarily from the complications of under-feeding. We would like to see evidence for the effectiveness of infant feeding observation schedules at detecting and promoting suitable interventions to prevent feeding-related difficulties, including insufficient intake, insufficient	Thank you for your comment. The committee agrees that poor feeding can lead to readmissions and this is why we have specifically included observing an effective feed before transfer of care to community care in the recommendation. We realise this alone was perhaps not sufficient and we have revised the recommendation by adding that before transfer of care to community there should be a plan for feeding the baby. We have also added a definition of 'effective feed'. Assessment of feeding should continue at every postnatal contact. The committee did not review evidence on the effectiveness of infant feeding observation schedules so the detail mentioned in the comment has not been covered.

				breast drainage, low supply, excessive weight loss, poor weight gain, jaundice, hypoglycaemia, hypernatremic dehydration, breastfeeding-related pain, mastitis, prolonged feeding times, overly frequent feeding and any other relevant physical and mental health factors impacting babies and parents	
Infant Feeding Alliance	Guideline	5	9	We point the committee to the fact that infant readmissions for jaundice and feeding complications more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017). Many of our babies were readmitted for complications from under-feeding after we were encouraged and supported to persist at exclusive breastfeeding in hospitals practicing the Baby Friendly protocol. We question whether the safeguards in these guidelines, such as timing the first midwife home visit to potentially 36 hours after discharge, are enough to prevent babies suffering unnecessarily from excessive weight loss, dehydration, jaundice and other complications of under-feeding. We advocate for clearer guidance as to the content of this visit, preventative measures taken, including weighing babies, and how best to use this visit to prevent adverse outcomes, such as readmissions to hospital as a consequence of under-feeding, or excessive maternal stress and sleep deprivation because of feeding difficulties. We also advocate that parents be told how to supplement	Thank you for your comment. The committee agrees that poor feeding can lead to readmissions and this is why we have specifically included recommendations that try to prevent poor feeding. For example, before transfer of care to community there should be a plan for feeding the baby, including observing an effective feed. We have added a definition of 'effective feed'. Assessment of feeding should continue at every postnatal contact. We have also added a recommendation that before transfer of care to the community or before departure of the midwife after homebirth, information should be provided about what to expect, what support is available and who to contact if there are any concerns at different stages. ****The content of the midwife visits are outlined in the guideline, including information provision, assessment of the baby's health, wellbeing and feeding as well as assessment of the health and wellbeing of the mother. Furthermore, the recommendation about communication between healthcare professionals at transfer of care has been revised to include baby's

				breastfeeding with formula, should they be worried that their baby is not getting enough milk. Some of us had the experience of babies becoming extremely hungry in this time period and were advised that frequent crying and feeding is normal. Our healthcare professionals offered 'reassurance' that amounted to little more than encouraging us to ignore our instincts and our babies' communication that they were still hungry after frequent and long breastfeeds. This caused immense distress to us and to our babies. In some instances, we were to learn that our babies had not been getting sufficient milk, resulting in admissions to hospital. It seems reasonable to us to inform parents how they can supplement breastfeeding with formula feeding, should they feel it is necessary or something that they might wish to do so, and that this does not need to spell the end of breastfeeding. Reassuring data suggests no association between modest formula supplementation and the timing of breastfeeding cessation (Flaherman et al., 2019b). Other data suggests that mothers who perceive themselves to have low milk supply are more likely to have biological markers of insufficient milk supply (Murase et al., 2016). We would be interested in the committee's opinion as to whether the risks of supplementing if a mother misperceives low milk supply are greater than the risks of not supplementing if she correctly perceives herself to have low milk supply. Our	feeding so that any issues or concerns would be clearly communicated between professionals.********The committee does not think it is advisable to routinely advise parents to supplement breastfeeding with formula if they have worries about milk supply or the baby's feeding but instead the mother should get appropriate and timely support with breastfeeding. Introducing formula feeding may indeed negatively impact milk supply and further hinder the 'success' of establishing breastfeeding. However, the committee agreed that if the mother chooses to or considers formula feeding or combining formula feeding with breastfeeding, she should get appropriate and respectful information and support to do so.

				perspective as mothers is that it is wholly unacceptable for a hungry baby to wait for milk and that we should know how to supplement breastfeeding with formula in the event of suspecting our babies are not satisfied with breastfeeding alone. We believe this would reduce maternal stress and lead to a more relaxed, enjoyable and sustainable approach to breastfeeding. Most importantly, it would prevent our babies suffering from hunger because we have been advised to persist with exclusive breastfeeding regardless of our baby's hunger cues. Indeed, we question how encouraging mothers to doubt their perception about their baby's hunger can possibly be considered 'responsive feeding'.	
Infant Feeding Alliance	Guideline	7	1	While we acknowledge that aspects of this provision relate to healthcare of the postnatal woman and should be addressed to her, we wish to point out that for many of us, caring for the baby in the early days and weeks was a responsibility shared with our partners. Therefore, we suggest that this section would relate more to the realities of UK families and be more inclusive if it was about communication with families or parents, rather than with women. The focus on women here seems to perpetuate a position where caring for the baby, especially feeding, is the primary responsibility of the woman.	Thank you for your comment. Based on stakeholder comments we have made some revisions to this section and throughout the guideline that in relation to the care of the baby we mainly refer to parents, not just the mother. We have added a definition of "parents" to the Terms used in this guideline section. However, the committee thinks that the focus of the guideline is still the woman and her baby so the guideline is woman-centred.
Infant Feeding Alliance	Guideline	7	11	As parents who fed our babies in different ways, we do not find the guidelines on infant feeding to be individualised or	Thank you for your comment. We strongly think that women should be fully supported with whatever feeding choices they make

				sensitive. The implication is that exclusive breastfeeding is something that should be 'encouraged' by healthcare providers. Your evidence review (Q) showed that many families are finding ways to 'share the load' by bottle feeding, which chimes with the experience of many of our members. We feel that the guidelines and the evidence reviews, by suggesting parents need to be informed on other ways partners can bond with babies and ways to avoid introducing formula, in fact undermine and stigmatise the way families are choosing to manage the demands of caring for a small baby by sharing feeding. This cannot be seen as personalised care. We would like to see consideration of a wider range of possibilities for feeding babies. For example, expressing milk for some feeds or feeding a baby a combination of formula and breastmilk. Although the current advice is to avoid giving any formula to a breastfed baby, this is not advice that the majority of families follow. One recent study suggests that the addition of a modest amount of formula is not associated with earlier breastfeeding cessation (Flaherman et al., 2019b). Families need to be aware of all methods available to them and to feel able to attend to their own needs and values	and we think the guideline reflects this. We have specifically made a recommendation about the general principles of babies' feeding which includes explicit statement of being respectful of parents' choices. Importantly, this recommendation also cross refers to the recommendation you are commenting on, meaning that discussions around feeding should follow the principles of information provision and be sensitive, individualised and respectful. ****Introducing formula when women are trying to establish breastfeeding may have an impact on the process of establishing breastfeeding and we have acknowledged this in the recommendations. This does not mean this is not an option, but we want to make sure women who are considering supplementing with formula are informed and supported adequately. Flaherman 2019b was not included in the evidence review as the comparison of breastmilk vs breastmilk plus formula was not a comparison of interest in any of the evidence reviews in the guideline. ****In relation to providing information about other ways that parents can bond with their babies. We have amended this recommendation based on your and others' feedback. Feeding is often seen as a way to comfort and soothe the baby even if the baby is not hungry, with formula this could sometimes lead to overfeeding and therefore it was considered important to share information to parents about finding other ways than feeding to comfort and soothe the

				(i.e., for sleep, to reduce stress, to have a break, to share responsibilities, fulfil responsibilities to other children or family members, or pursue personal interests) and to make decisions that best meet their particular needs.	baby. We have taken out 'partners and other family members' because this applies to whoever might be caring for the baby (including the mother).****We recognise that mixed feeding is an option and common practice and this was inadvertently not captured in the draft recommendations so we have added a recommendation that acknowledges that babies may be partially formula fed. Giving expressed milk is also recognised as an option and covered by the breastfeeding section and we have further revised this particular point in the recommendation based on stakeholder feedback.
Infant Feeding Alliance	Guideline	7	13	Your evidence reviews (P, Q, R, S) found no evidence for interventions to increase breastfeeding rates and were vague on what practical interventions actually help to solve breastfeeding problems and in many cases the committee relied on its expertise and knowledge. This matches what we found when searching the literature. The latest Cochrane review for managing breastfeeding-related nipple pain found insufficient evidence to make recommendations (Dennis et al., 2014), and we were unable to identify any similar review of interventions to manage difficulties with latching or maternal report of low milk supply. The guidance on practical support seems to rely heavily on Baby	Thank you for your comment. The NICE guideline development process includes that when there is no research evidence or the research evidence is inconclusive or poor quality, the committee can use their knowledge and experience to make consensus-based recommendations. The committee discussed that the limited impact that different clinical interventions provided within the healthcare system seem to have on breastfeeding rates likely reflect that there are wider societal and public health interventions that would affect breastfeeding rates more but these are outside the scope of this guideline. Despite the lack of clear evidence on clinical interventions to improve breastfeeding rates, the evidence did inform the committee about the different information that women may find

				Friendly Initiative (BFI) guidelines, even though your own quality assessment (Evidence Review F) found that these guidelines did not score highly, i.e. 'Recommendations are quite vague and different options are not discussed'. In general, the guidelines reviewed in your search 'scored poorly (<70%) in the "applicability" domain' (Evidence Review F). Therefore we question whether the infant feeding guidelines here can be truly considered 'evidence-based' and whether they can be practiced consistently. The lack of evidence that breastfeeding support and interventions can prevent or resolve common breastfeeding problems must be transparent to women. Only then can they make an informed decision about whether to avail themselves of these services. Healthcare workers must be honest with us about the uncertainty as to how effective this advice is likely to be at resolving breastfeeding-related problems or helping to make breastfeeding a sustainable long-term way to feed a baby. Additionally, acknowledgement ought to be made of the full range of families' feeding experiences and the variety of ways families navigate sharing early infant care. This would include how some sustain exclusive breastfeeding if	beneficial and the different approaches that might be helpful in supporting them. The guidance on practical support is on the evidence reviews and the committee's knowledge and experience. However, due to lack of evidence on useful validated tools the recommendations on breastfeeding assessment are partly based on the BFI breastfeeding assessment tool which is widely used in current practice and which the committee agreed includes many good practice points. We did not review evidence about what interventions can prevent or resolve common breastfeeding problems. However we reviewed qualitative evidence about women's views and experiences in relation to facilitators and barriers for starting and maintaining breastfeeding and these data informed the recommendations. The committee agrees that the full range of feeding experiences and ways should be acknowledged, supported and respected. The committee thinks this is reflected in the recommendations we have made about providing respectful, sensitive and individualised care.

				desired and how others find mixed feeding or formula feeding more suited to their families' needs.	
Infant Feeding Alliance	Guideline	8	13	We are aware of a growing field of sleep medicine and the importance of night-time sleep, consistency and circadian rhythms for adults. We would like greater clarity for parents and those supporting them to recognise when sleep deprivation is a clinical concern that warrants treatment in its own right. This might be through practical problem-solving to ensure parents maximise their opportunities to sleep, behavioural sleep interventions for adults adapted to the postnatal period, or, in some cases, prescribed medication. Given the growing recognition of the effectiveness of psychological interventions for insomnia (i.e., CBT-I), we propose a future research direction might be to examine how these can best be utilised to support parental sleep in the early postnatal period. For many of the mothers among us, sharing feeds with another person at night was essential to our self-care and our physical and psychological wellbeing. It allowed us to get a block of sleep of several hours, which was impossible to get if we were the sole provider of food to the baby. We do not see that 'discussing' fatigue with women without putting all practical solutions on the table (i.e. introducing a bottle in the evening, mixed feeding or formula feeding) is helpful. Indeed, it may contribute to the idea that it is 'normal' and should simply be battled	Thank you for your comment. The committee recognises the importance of this topic but this is not something we reviewed evidence on and therefore we have not made any detailed recommendations on it. However, the committee wanted to include it in the topics to discuss because of its importance.

				through. Sleep deprivation is a significant risk factor for physical and mental illness, stress, anxiety, mood disturbance, irritability, inflexible thinking, relationship tensions and more. It has zero benefits. It must be taken seriously. When it comes to making decisions about infant feeding and the possibility of sharing feeding responsibilities, particularly at night, any benefits of exclusive breastfeeding must be weighed up against the risks of sleep deprivation for women who are experiencing breastfeeding as fatiguing.	
Infant Feeding Alliance	Guideline	14	25	We point the committee to the fact that infant readmissions for jaundice and feeding complications more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017). Many of our babies were readmitted for complications from under-feeding after we were encouraged and supported to persist at exclusive breastfeeding in hospitals practicing the Baby Friendly protocol. We question whether the safeguards in these guidelines, such as weighing once at an unspecified time in the first week, are enough to prevent babies suffering unnecessarily from excessive weight loss, dehydration, jaundice and other complications of under-feeding. We would ask the committee to consider the one intervention we are aware of that prevents early readmissions: early limited formula supplementation (Flaherman et al., 2013, 2018b, 2019a; Straňák et al., 2016).	Thank you for your comment. The recommendation on weight measurement within the first week is based on the UK-WHO Growth Charts and is in addition to the assessment of the baby's health, wellbeing and feeding. If there are any concerns, additional measurements should be carried out. We have referred to the NICE guideline on faltering growth if there are any concerns with the baby's growth and therefore, we have not made any further recommendations about how to manage this.

Infant Feeding Alliance	Guideline	14	28	While the guideline here refers to other NICE guidelines on managing jaundice, which are outside the scope of these comments, we would highlight that, in our experience, parents are not being clearly informed: a) that exclusive breastfeeding is a leading risk factor for jaundice, b) of other factors that increase their baby's risk of jaundice (i.e. mode of delivery) and c) that supplementation can be used as a preventative measure if babies are at risk of jaundice. As parents, we experienced distressing readmissions for jaundice, and endured anxiety and upset as we watched our newborn babies go through phototherapy treatment that could have been avoided through supplementation. We would again point the committee towards the fact that readmissions for jaundice more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017) and we would ask them to consider whether present safeguards are enough to prevent this. We stress again that the only intervention that has strong support for preventing jaundice is early limited formula supplementation (Flaherman et al., 2018b). At a minimum, parents should be aware of the possibility to reduce the need for phototherapy and a readmission for jaundice by supplementing breastfeeding with formula, so they can make their own informed decision. We would like to see greater clarity regarding when introducing supplementary formula to babies who have	Thank you for your comment. As you say, assessment and management of jaundice is covered by another NICE guideline. We think that the recommendations in the guideline should lead to concerns being picked up early so that readmissions could avoided as much as possible. We have amended the recommendation about supplementing breastfeeding with formula to state that sometimes, but not commonly, supplementary feeding with formula milk is clinically indicated.

				been exclusively breastfed is considered clinically necessary.	
Infant Feeding Alliance	Guideline	17	2	Given the lack of evidence found for benefits or harms of any interventions relating to bonding (Evidence Review O), we find it concerning that the committee makes such heavy-handed recommendations about promoting bonding and emotional attachment. As parents, we found such recommendations to undermine our confidence and be anxiety-inducing, intrusive and unhelpful, especially in the stressful postnatal period. We found that bonding happened when pressure was taken off us and we were given space to develop our relationships with our babies. We think it is important for healthcare providers not to overstep healthcare provision into interference with family life. In our experience, such interference can cause unnecessary worry and stress and lead to distrust of healthcare providers	Thank you for your comment. It is unfortunate that the recommendations have been perceived as being anxiety-inducing, intrusive and unhelpful. This is certainly not the aim, quite the contrary. The committee, which included lay members, made the recommendations based on their knowledge and experience with the intention to highlight that parents should be encouraged to value the quality time they already spend with their babies, caring, cuddling and interacting with them. The committee are also aware that many parents and families may struggle with developing the parent-infant relationship because of various pressures and stresses in the postnatal period and wanted to highlight some of the issues that might be discussed in order to help the parents navigate through the postnatal period, developing their relationship with their baby with the support from the healthcare professionals.
Infant Feeding Alliance	Guideline	17	5	We could find no evidence in the evidence reviews that families are not valuing the time with their babies and need to be reminded of this! We think it is important for healthcare providers not to overstep healthcare provision into interference with family life. In our experience, such interference can undermine parental confidence, cause unnecessary worry and stress and lead to distrust of healthcare providers. We also	Thank you for your comment. In the committee's experience, most parents bond with their babies naturally through their own ways of interacting and responding to their babies' cues and needs. However, many parents also feel immense pressure about how to best bond with their baby and how to promote their development and emotional attachment. The committee, which included lay members, made the recommendations

				question whether advising parents on what to value is in line with NICE principles of personalised care: 'This requires healthcare professionals to recognise the individual, and for services to be tailored to respond to the needs, preferences and values of the patient'. Please respect the unique and individual ways that emotionally responsive and loving families find to connect with each other. Please refrain from overstepping the role of healthcare provider with overly prescriptive advice not grounded in solid evidence of health benefits. We suggest that communicating trust in parents and their ability to find their own ways to bond and relate to their baby would be respectful, reassuring and confidence-boosting for families.	based on their knowledge and experience with the intention to highlight that parents should be encouraged to value the quality time they already spend with their babies, caring, cuddling and interacting with them. There are of course unique and individual ways how parents interact and spend quality time with their babies and the recommendations are not aiming to prescribe any specific ways how to do this but instead encourage parents that what many of them naturally do through face-to-face interaction, skin-to-skin contact and responding to the baby's cues, is how the babies develop attachment.
Infant Feeding Alliance	Guideline	17	8	The most recent Cochrane review into the effects of skin-to-skin highlights methodological weakness in the trials, but recommends skin-to-skin on the basis of relatively weak evidence of benefit and lack of evidence of harm (Moore et al., 2016). We point the committee towards recent reports suggesting rare but potentially catastrophic risks of skin-to-skin, including sudden unexpected postnatal collapse and newborn falls (Bass et al., 2017; Goldsmith, 2013). We also point towards the recent HSIB report into SUPC occurring when babies are in skin-to-skin contact (HSIB, 2020). This highlighted the need to ensure optimal positioning of the baby to protect their airway, as well as monitoring babies' skin	Thank you for your comment. It should be noted that we did not review the evidence on the benefits and harms of skin-to-skin contact for this guideline. However, we did look for, but did not identify, relevant evidence in relation to giving information about skin-to-skin contact and how that might impact emotional attachment. Based on the NICE guideline development methods and processes, in the absence of evidence, the committee can make consensus-based recommendations. The recommendation about encouraging parents to value the time they spend with their babies, including skin-to-skin, is based on the committee's knowledge of the overall benefits of skin-to-skin contact and the knowledge that many

				colour, tone and temperature while in skin-to-skin. We also suggest that parents should be advised about safety issues related to skin-to-skin contact at home, such as the effects of medications, sleep deprivation or other factors that might impact on parental alertness and how to ensure optimal positioning and keep babies safe while in skin-to-skin contact. We also point out that the benefits of skin-to-skin as communicated in antenatal education are often considerably exaggerated in comparison to the benefits identified in systematic reviews of the literature, such as the 2016 Cochrane review. While many families enjoy skin-to-skin, we should not be under pressure to practice it with information from our trusted healthcare providers that exaggerates the health effects of having or not having skin-to-skin contact. We stress again, that family members find their own unique and intuitive ways to connect with each other. Healthcare providers should avoid interfering with family life with prescriptive guidelines that are not based on solid evidence of significant health impact.	parents practice this naturally when they care and cuddle their babies. The committee agrees that parents should not be pressured to practice skin-to-skin but they should rather be encouraged to value the ways in which they spend quality time interacting with their babies. We have made recommendations about safer practices for bed sharing/co-sleeping which cover some of the aspects and concerns you mention. Sleeping in skin-to-skin contact are certainly not recommended.
Infant Feeding Alliance	Guideline	17	15	As parents, many of us found that when exclusive breastfeeding turned out to be extremely difficult, painful, or involved excessive sleep deprivation, frequent feeding and infant readmission, this contributed to difficulties with bonding with our babies. Bottle feeding provided a solution. For some, breastfeeding was straightforward and enjoyable. For others, combining	Thank you for your comment. In finalising the guideline the committee agreed to edit this recommendation so it now refers to 'feeding concerns' as being possibly challenging and something that could affect bonding. The recommendations in this section do not state that formula feeding should be a cause for concern in terms of bonding and emotional attachment. There is however a

				breastfeeding and formula feeding or expressing milk were important aspects of how we fed our baby, cared for ourselves and build a nurturing family environment for our whole families. It is clear to us that if a feeding method is painful, stressful or exhausting, it will not be good for bonding, but if it is working, is convenient and creates a relaxed atmosphere, it can contribute to bonding. However, the present guidelines present exclusive breastfeeding as always superior due to selected health benefits. Meanwhile, mixed feeding is not included, and formula feeding is presented as something that parents will need special help to bond if doing. As parents who fed and bonded with our babies in different ways, we do not find this situation acceptable. It is frankly insulting to suggest that parents who decide to formula feed will need additional help with bonding.	recommendation in the section on formula feeding which states that support in this context should include how to bond with the baby when bottle feeding, for example through skin to skin contact. The committee made this recommendation with the intention of ensuring all women - regardless of the way they feed their baby - receive the same kind of support and information regarding the importance of bonding and the role of things like skin to skin contact.
Infant Feeding Alliance	Guideline	20	7	We do not understand what is meant by the 'environmental impact' of feeding decisions and we could find no evidence in any evidence reviews of where this recommendation comes from or on what the environmental impact of different feeding methods is. We do not believe it is a healthcare provider's role to advise parents on making better 'environmental' choices.	Thank you for your comment, which the committee discussed. On the basis of their experiential knowledge they did feel that in fact parents are increasingly thinking about the impact that various choices have upon the environment. On the other hand they recognise that it is isn't the role of professionals to lecture parents about such things as the negative environmental effects of dairy farming but they should acknowledge any such concerns that parents might have. The committee therefore agreed to edit the wording of the recommendation in line with this, which now reads 'acknowledge

					the parents' emotional, social, financial and environmental concerns about feeding options...'
Infant Feeding Alliance	Guideline	20	9	We do not believe the present guidelines enable healthcare providers to be respectful of feeding choices. The guidelines present benefits of breastfeeding without acknowledging that exclusive breastfeeding is not a reasonable choice for many families. They do not acknowledge mixed feeding. They suggest only families committed to formula feeding receive info on formula (although your own Evidence Review T showed that families wanted this). The committee seems concerned about parents sharing feeding by bottle feeding and so advises that partners should be told of other ways to bond with baby. It is clear that where evidence was not found, the committee rested on an ethos very much in line with the Baby Friendly Initiative. We point the committee to specific Baby Friendly guidelines that stigmatise formula feeding and are not respectful of parents' choices: -Formula is withheld from parents unless 'medically necessary' -Healthcare providers should 'remain steadfast in their messaging about the superiority of breastfeeding' when providing information to parents about formula feeding -No information or positive images of bottle feeding should be on public display -Formula feeding shouldn't be discussed antenatally in the presence of women who are planning to breastfeed -Referring to formula feeding as 'artificial	Thank you for your comment. The committee made some revisions to the feeding recommendations based on your and other stakeholders' comments. The committee agrees that the draft guideline did not acknowledge mixed feeding clearly enough so in the revisions we have tried to make this clearer. The recommendation remains that in the antenatal period, information about formula feeding should be given to anyone who considers it. We recognise that women do not always decide during pregnancy how they will feed their baby so many women would likely consider the option of formula feeding and these women should get information about it. We have also revised the recommendation about "other ways to bond with their baby" to not address partners or other family members in particular but be more general about finding other ways than feeding to comfort and soothe the baby. Feeding may be used as a way to comfort the baby and this can potentially lead to over feeding in formula fed babies. It should be noted that Baby Friendly Initiative standards were not reviewed by the committee and no direct reference is made to them in the recommendation. Many of the recommendations align with the UNICEF Baby Friendly Initiative principles, however, this is not to say that the guideline reflects all of their principles. For example, parental

				feeding'. (UNICEF UK, 2014) Current policy in the UK reduces parental choice. For example, we are not aware of any NHS hospital that has a newborn nursery that parents can choose to use should they wish. Rather, a policy of rooming-in is enforced, requiring a mother to assume 24-7 care of her newborn, regardless of her physical or mental condition after the birth of her baby. This is part of the Baby Friendly Initiative approach, which sees rooming-in as conducive to breastfeeding. A recent Cochrane review found only one trial, which was deemed to be low quality of evidence, suggesting that rooming-in might increase the rate of exclusive breastfeeding in the days after birth, but not the proportion of babies breastfeeding at six months of age (Jaafar et al., 2016). Its conclusion was that there was insufficient evidence to support or refute the practice. A more recent meta-analysis drew the same conclusion (Ng et al., 2019). Given that the evidence is equivocal, we propose that enforcing this on all families, regardless of their wishes or needs, is a violation of patient autonomy. Given the potential benefits of being able to use a newborn nursery during the postnatal hospital stay if a mother feels unwell or needs to rest, this should be an option available to families.	choice on feeding is emphasised in the guideline and respectful, non-judgmental and individualised discussions are recommended. ****Rooming-in was not in the scope of this guideline so no recommendations have been made related to that.
Infant Feeding Alliance	Guideline	20	11	We do not believe the guidelines can properly support UK parents or reflect their reality if they separate breastfeeding and formula feeding in this way. Your own	Thank you for your comment. The committee made some revisions to the feeding recommendations based on your and other stakeholders' comments. The committee

				evidence reviews found that parents felt unprepared for the realities of breastfeeding and for formula feeding if it was not planned, and that they did not feel informed about supplementation (Evidence Reviews P, Q, R, S). As parents, we would like to see 'infant feeding' information (rather than 'Breastfeeding' and 'Formula Feeding' information) presented to all families antenatally, and postnatally if needed, so that they can make a fully informed choice about what will work best for them and so they can be prepared if things don't go to plan. We would like to see mixed feeding acknowledged as a good option.	agrees that the draft guideline did not acknowledge mixed feeding clearly enough so in the revisions we have tried to make this clearer. The recommendation remains that in the antenatal period, information about formula feeding should be given to anyone who considers it. We recognise that women do not always decide during pregnancy how they will feed their baby so many women would likely consider the option of formula feeding and these women should get information about it.
Infant Feeding Alliance	Guideline	20	13	We do not believe this unbalanced presentation of benefits of breastfeeding is in line with NICE's idea of personalised information. Different feeding methods have different benefits for different families. There is far more uncertainty in breastfeeding research than is acknowledged here and causation cannot be proven for the majority of these benefits, so selling breastfeeding to parents as having vast benefits for all babies is misleading. We would like to see parents presented with accurate and understandable information and statistics on the absolute benefits and risks of different feeding methods antenatally. This must include risks associated with exclusive breastfeeding, such as excessive weight loss, jaundice and dehydration (Flaherman et al., 2018a; Tarcan et al., 2005). In the postnatal period, when families are already feeding their baby,	Thank you for your comment. The committee reviewed the guideline in light of the points you make. They acknowledge that the feeding recommendations were made in the context of the widely accepted health benefits for women and babies, which are linked with breastfeeding. However they did agree to 'soften' the wording of the recommendation to which you refer. Instead of recommending that healthcare professionals 'explain to women that breastfeeding has benefits...' it is now recommended that the potential benefits of breastfeeding might be topics for discussion in the context of providing information and support for breastfeeding. The committee are content that this would not lead to overstating the benefits of breastfeeding. They also took care to ensure that in finalising the guideline, there was a better

				we do not believe it is acceptable for this information to be delivered in an unsolicited way by healthcare providers. We also point to a recent qualitative study which found that some women felt desperate to stop breastfeeding but under pressure to continue (Ayers et al., 2019). We find it unacceptable that parents are being told about the benefits of breastfeeding in an overstated way, without acknowledgment that these benefits must be weighed up against the risks, including the risks of continuing to breastfeed through painful, stressful and unhappy breastfeeding experiences. Conversations about the health effects of infant feeding decisions need to be scientifically balanced and responsive to the experiences and needs of families in the postnatal period.	balance in terms of recognising that for some parents supplementary feeding might be the preferred or more suitable option compared with exclusive breast or formula feeding. For example, one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. There is also a recommendation about supporting parents in their decision making when they are considering supplementing breastfeeding with formula or changing from breastfeeding to formula feeding. Having finalised the guideline, including taking account of your comments, the committee now feel their recommendations about the provision of information and support for feeding reflect the importance of practitioners being respectful, person centred and non-judgemental.
Infant Feeding Alliance	Guideline	21	18	Your evidence reviews (P, Q, R, S) found no evidence for interventions to increase breastfeeding rates and were vague on what practical interventions actually help to solve breastfeeding problems. This matches what we found when searching the literature. The latest Cochrane review for managing breastfeeding-related nipple pain found insufficient evidence to make recommendations (Dennis et al., 2014), and we were unable to identify any similar review of interventions to manage difficulties with latching or maternal report of low milk supply. Your guidance on practical support	Thank you for your comment. The NICE guideline development process includes that when there is no research evidence or the research evidence is inconclusive or poor quality, the committee can use their knowledge and experience to make consensus-based recommendations. The committee discussed that the limited impact that different clinical interventions provided within the healthcare system seem to have on breastfeeding rates likely reflect that there are wider societal and public health interventions that would affect breastfeeding rates more but these are outside the scope

				seems to rely heavily on Baby Friendly Initiative (BFI) guidelines. However, your own quality assessment (Evidence Review F) found that these guidelines did not score highly, i.e. 'Recommendations are quite vague and different options are not discussed'. In general, the guidelines reviewed in your search 'scored poorly (<70%) in the "applicability" domain' (Evidence Review F). Therefore, we question how effective healthcare providers can be at resolving common breastfeeding problems and whether parents are being properly informed about this. Your evidence review (Q) found that women were not informed about supplementation. We would point the committee to recent evidence from randomised controlled trials that demonstrated that early limited supplementation with formula does not increase breastfeeding cessation but does reduce babies' risk of readmission to hospital with feeding-related complications (Flaherman et al., 2013, 2018b, 2019a; Straňák et al., 2016). We do not feel the guidelines adequately equip healthcare providers to recommend supplementation or families to understand that it does not necessarily mean an end to breastfeeding. We are concerned in general about a seeming lack of awareness in the guidelines about the severity and frequency of breastfeeding problems. As parents, we found breastfeeding problems to be far from trivial blips, but to contribute to serious	of this guideline. Despite the lack of clear evidence on clinical interventions to improve breastfeeding rates, the evidence did inform the committee about the different information that women may find beneficial and the different approaches that might be helpful in supporting them. The guidance on practical support is on the evidence reviews and the committee's knowledge and experience. However, due to lack of evidence on useful validated tools the recommendations on breastfeeding assessment are partly based on the BFI breastfeeding assessment tool which is widely used in current practice and which the committee agreed includes many good practice points. We did not review evidence on what interventions can prevent or resolve common breastfeeding problems or supplementation of formula to breastfeeding, however, we reviewed qualitative evidence on women's views and experiences on facilitators and barriers for starting and maintaining breastfeeding which informed the recommendations. The committee discussed the importance of respecting the parents' choice with regards to feeding their baby, which is reflected in a recommendation in the section on general principles about babies' feeding. By respecting parents' choice, we aim for a compassionate and person-centred approach, and acknowledge that not all babies fall into the category of being solely breastfed or formula fed, but can be a combination of both which the committee

				mental health issues, infant readmissions, excessive sleep deprivation and not enjoying time with our babies. We question whether the guidelines empower healthcare providers to take a compassionate and person-centred approach if the severity of these problems is not taken seriously and if they are motivated to 'encourage' women to maintain breastfeeding, rather than discussing all options with parents so they can make a decision according to their needs. We also point to a recent qualitative study which found that some women felt desperate to stop breastfeeding but under pressure to continue (Ayers et al., 2019). We find it unacceptable that parents are being told about the benefits of breastfeeding in an overstated way, without acknowledgment that these benefits must be weighed up against the risks, including the risks of continuing to breastfeed through painful, stressful and unhappy breastfeeding experiences. Conversations about the health effects of infant feeding decisions need to be scientifically balanced and responsive to the experiences and needs of families in the postnatal period.	recognised as being important and has therefore been added as a recommendation to the formula feeding section.
Infant Feeding Alliance	Guideline	22	9	We fail to see how healthcare providers can help parents by discussing the emotional impact of breastfeeding, while the solutions parents are finding are viewed as 'barriers to breastfeeding' (Evidence Review Q: Facilitators and Barriers to Breastfeeding). Your own evidence review (Q) shows that	Thank you for your comment. The issues you raise were echoed in the evidence review on breastfeeding information and support which found that women experience a wide range of emotions with regards to breastfeeding, including guilt, pressure, failure and alienation. It is for this reason the committee felt it was important that anyone providing

				families are finding ways to deal with the difficulties of the postnatal period by sharing feeding, but the committee appears to see this as a problem. We also think it is important to note that a recent review of the Baby Friendly Initiative suggests adverse effects of the current approach on maternal mental health and emotional wellbeing (Fallon et al., 2019). We know of no study specifically examining the emotional and mental health effects of current policies regarding infant feeding. Given substantive qualitative evidence highlighting negative experiences, we suggest that the psychological impact must be a priority for research. Evidence is needed to reform current policies and practice in ways that promote the emotional wellbeing of families in the postnatal period.	support for breast feeding should be fully cognizant of the sometimes negative emotional and mental health effects of perceived pressure to breast feed. On reflection the committee therefore did not feel there was any need to alter this recommendation.
Infant Feeding Alliance	Guideline	22	13	We do not believe care can be tailored to the woman's individual needs if it is considered 'breastfeeding care' rather than infant feeding support, in which introducing formula is a sensible solution to dealing with difficult problems and may help her to continue some breastfeeding.	Thank you for your comment. We have revised some of the recommendations in the feeding section, for example by more clearly acknowledging mixed feeding. However, it should be noted that the committee's view is that while supplementing with formula may sometimes be a sensible option, it also risks the success of breastfeeding particularly if breastfeeding has not been established yet. The main heading of the feeding section is generally about babies' feeding, however, there are aspects to both breastfeeding and formula feeding that are quite specific,

					therefore, it is sensible to keep these topic separated, even if both topics apply to some women who are practicing mixed feeding and changing from one method of feeding to another.
Infant Feeding Alliance	Guideline	23	20	We feel that any guidance about introducing expressing into a feeding routine needs to take into account a woman's need to sleep and take care of other needs. As parents we found practices like this, which introduced another step into the process of feeding, were recommended with no acknowledgement of what they entailed and proved harmful to our wellbeing and in some cases to contribute to postnatal mental illness. For example, the NICE guidelines on faltering growth recommend expressing milk between each breastfeed. As babies feed frequently, this leaves little time for sleep or indeed, anything else, which puts a great deal of pressure on the woman and has obvious potential to be detrimental to her physical and mental health.	Thank you for your comment. The committee agrees that different implications of the choices being made should be discussed and that is why the stem of the recommendation says "Provide information, advice and reassurance about breastfeeding, so women (and their partners) know what to expect..." For some women, expressing breast milk will not be a useful option. As far as we know, the NICE faltering growth guideline does not state that expressing breast milk should be done between each feed but instead that expressing should be advised in order to promote milk supply.
Infant Feeding Alliance	Guideline	23	23	We would suggest that 'when to seek help' is when the woman is suffering and needs pain relief or a solution to the problem, not when a healthcare professional deems she should. We are concerned by a lack of seriousness around women's pain in the evidence reviews, which told some harrowing stories. Evidence Review Q found that women feel the need to persevere through breastfeeding pain, that they	Thank you for your comment. The recommendation on 'when to seek' help is not intended to be an exhaustive list set by a healthcare professional about the only times women should seek help, but rather a helpful guide on situations when women may need further assistance. We fully agree that the woman should seek help if she is in pain and suffering, the guideline is written with the woman at the centre and we have emphasised the importance of being respectful of the woman's feeding choice as

				sometimes dreaded the next feed, or it impacted on their bond with their baby. We urge the committee to consider why women are feeling the need to endure pain. Is this connected to the promotion of breastfeeding and the promise that breastfeeding support can resolve all issues (Evidence Review S)? We would point the committee to the fact that neither the evidence reviews nor the latest Cochrane review found evidence for interventions to help with pain (Dennis et al., 2014). Health professionals must be honest with women about the lack of evidence for what might help with pain and accept a woman's autonomy to decide she is no longer willing to persist with painful feeding. Where a woman is experiencing painful feeding that is not quickly resolved by current supports, any benefits of breastfeeding must be weighed up against the risks of persistently painful feeding. **********	a recommendation at the start of the feeding section, whether this means exclusively breastfeeding, formula feeding, combination feeding, or switching from breastfeeding to formula feeding. In evidence review P, there was no clear direction from the evidence as to the precise nature of breastfeeding interventions that would significantly increase breastfeeding rates. In the absence of evidence, NICE allows the committee to make recommendations based on their knowledge and experience, in view of this the committee formulated recommendations based on their knowledge and expertise for breastfeeding support in combination with qualitative evidence from evidence review S. The recommendations for supporting breastfeeding are there to try to help those women who want to continue breastfeeding and not feel as if she has to stop due to difficulties, however if the woman decides she wants to stop breastfeeding the healthcare professional should be respectful of her choice.
Infant Feeding Alliance	Guideline	23	26	In our experience as parents, we know of only one intervention that is effective at treating fatigue in the postnatal period: sharing feeds with another person, especially at night. This allows a mother to potentially get a block of sleep of several hours, that she cannot get if she is the sole provider of food to the baby. We do not see that 'discussing' fatigue with women, without putting all practical solutions on the table, is	Thank you for your comment. We have revised the recommendation to say "strategies to manage fatigue when breastfeeding" but have not given details what these should be as we have not reviewed the evidence.

				helpful, indeed it may contribute to the idea that it is 'normal' and should simply be battled through. Since excessive sleep deprivation is a risk factor for postnatal mental illness, normalising it can be harmful.	
Infant Feeding Alliance	Guideline	23	27	Regarding disadvantages of supplementation, we would point to recent evidence from randomised controlled trials that has demonstrated that early limited supplementation with formula does not increase breastfeeding cessation but does reduce babies' risk of readmission to hospital with feeding-related complications (Flaherman et al., 2013, 2018b, 2019a; Straňák et al., 2016). Another recent paper found up to 4 fl oz formula per day was not associated with earlier cessation of breastfeeding, suggesting combination feeding is a viable long-term possibility for those that wish to do so (Flaherman et al., 2019b). We would also point to the committee's own evidence reviews that showed that women 'appreciated the flexibility of mixed feeding' (S) and that many families are finding ways to thrive by sharing feeding (Q).	Thank you for your comment. We have amended the recommendation to "supplementary feeding with formula milk may sometimes be clinically indicated" with cross-reference to faltering growth guideline. A new recommendation has been added to the guideline under formula feeding to support women who are considering combination feeding or switching from breastfeeding to formula feeding as suggested, rather than just discussing advantages and disadvantages. Evidence on around the supplementation of formula to breastfeeding wasn't included in our guideline as it didn't meet the inclusion criteria of any of the evidence reviews.
Infant Feeding Alliance	Guideline	24	2	We question whether there is an overstating of what practitioners can do to 'address' breastfeeding concerns. Your evidence reviews (P, Q, R, S) found no evidence for interventions to increase breastfeeding rates and were vague on what practical interventions actually help to solve breastfeeding problems. This matches what	Thank you for your comment. The NICE guideline development process includes that when there is no research evidence or the research evidence is inconclusive or poor quality, the committee can use their knowledge and experience to make consensus-based recommendations. The committee discussed that the limited impact that different clinical interventions provided

				we found when searching the literature. The latest Cochrane review for managing breastfeeding-related nipple pain found insufficient evidence to make recommendations (Dennis et al., 2014), and we were unable to identify any similar review of interventions to manage difficulties with latching or maternal report of low milk supply. Your guidance on practical support seems to rely heavily on Baby Friendly Initiative (BFI) guidelines. However, your own quality assessment (Evidence Review F) found that these guidelines did not score highly, i.e. 'Recommendations are quite vague and different options are not discussed'. In general, the guidelines reviewed in your search 'scored poorly (<70%) in the "applicability" domain (Evidence Review F)	within the healthcare system seem to have on breastfeeding rates likely reflect that there are wider societal and public health interventions that would affect breastfeeding rates more but these are outside the scope of this guideline. Despite the lack of clear evidence on clinical interventions to improve breastfeeding rates, the evidence did inform the committee about the different information that women may find beneficial and the different approaches that might be helpful in supporting them. The guidance on practical support is on the evidence reviews and the committee's knowledge and experience. However, due to lack of evidence on useful validated tools the recommendations on breastfeeding assessment are partly based on the BFI breastfeeding assessment tool which is widely used in current practice and which the committee agreed includes many good practice points. We did not review evidence on what interventions can prevent or resolve common breastfeeding problems, however, we reviewed qualitative evidence on women's views and experiences on facilitators and barriers for starting and maintaining breastfeeding which informed the recommendations.
Infant Feeding Alliance	Guideline	24	14	We point the committee to the fact that infant readmissions for jaundice and feeding complications more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017). Many of our babies were readmitted for complications from under-feeding after	Thank you for your comment. The committee agrees that poor feeding can lead to readmissions and this is why we have specifically included observing an effective feed before transfer of care to community care in the recommendation. We realise this alone was perhaps not sufficient and we

				we were encouraged and supported to persist at exclusive breastfeeding in hospitals practicing the Baby Friendly protocol. We question whether the safeguards in these guidelines, such as observing a feed once in the first 24 hours and at another unspecified time in the first week, are enough to prevent babies suffering unnecessarily from excessive weight loss, dehydration, jaundice and other complications of under-feeding.	have revised the recommendation by adding that before transfer of care to community there should be a plan for feeding the baby. We have also added a definition of 'effective feed'. Assessment of feeding as well as infant wellbeing should continue at every postnatal contact.
Infant Feeding Alliance	Guideline	24	19	The committee seems unconcerned by intractable breastfeeding problems here and what will happen if they do not resolve. There seems to be very little consideration of the baby's need to eat and more of a focus on breastfeeding as an outcome in itself. Why is supplementation with formula not one of the options here? Even if a woman wishes to keep breastfeeding, we would point to recent evidence from randomised controlled trials that has demonstrated that early limited supplementation with formula does not increase breastfeeding cessation but does reduce babies' risk of readmission to hospital with feeding-related complications (Flaherman et al., 2013, 2018b, 2019a; Straňák et al., 2016). Where is the evidence that positioning and attachment, expressing breastmilk and tongue- tie assessment or surgery impacts breastfeeding problems? We are still awaiting the results of an RCT looking at whether tongue- tie surgery	Thank you for your comment, in light of which the committee made changes to the final version of the guideline. For example, in the recommendation to which you refer, 'other actions' (if there are ongoing concerns) now include referring to additional support such as a lactation consultant or peer support. They also edited one of the recommendations in the section on formula feeding, so that practitioners take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk.

				improves breastfeeding continuation (https://www.npeu.ox.ac.uk/frosttie). Clinical recommendations should not come in advance of research evidence that allows their likely benefits and harms to be understood.	
Infant Feeding Alliance	Guideline	25	3	All parents need all information on all options in order to make an informed decision about what method might work for them and should things not go to plan. As your evidence review shows (T), families want information on formula feeding antenatally, not only if they plan to formula feed. We find it unacceptable that despite this, the committee concludes that families shouldn't be given the information on formula feeding. Many women plan to breastfeed but find it harder than they had anticipated, as your evidence review found (Q). Many families do both. Feeding information and support needs to be flexible. It needs to acknowledge that plans change, no decision is set in stone and that families are not 'breastfeeding families' or 'formula feeding families'. The fact remains that the vast majority of babies in the UK will receive some formula at some point in their lives. Therefore, this information is required by the vast majority of parents. Withholding this information is senseless, potentially causing needless confusion about what milk to purchase, how to prepare formula safely and how to keep feeding equipment clean.	Thank you for your comment. The committee discussed your point and are still of the view that in light of the additional health benefits for women and babies from breastfeeding and in view of the enormous amount of information given during the antenatal period then information about formula feeding should be given to families who are thinking about (and therefore may still be undecided) or who need to formula feed. The committee feel their recommendations about the provision of information and support for formula feeding reflect the importance of practitioners being respectful, person centred and non-judgemental. That said, they did make some changes to the formula feeding recommendations, in light of yours and other stakeholder comments. For example, one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. They had already recommended that advice about safe storage and preparation of formula and expressed breast milk be given to parents and that parents should be told that first infant formula is the only formula milk babies

					need in the first year these have remained in the final version of the guideline.
Infant Feeding Alliance	Guideline	25	5	Despite the fact that parents want more info antenatally and are not given it, these guidelines suggest that healthcare providers offer information postnatally that cannot possibly be helpful and can only be stigmatising. We fail to understand the rationale for a healthcare provider telling a family who are successfully formula feeding in an unsolicited way the 'differences between breastmilk and formula'. Please do not patronise us. We want only the absolute benefits and risks of each feeding method in a balanced way and then we can make our own autonomous decisions.	Thank you for your comment. The recommendations on babies' feeding are covering both antenatal and postnatal periods so there has been a misunderstanding with this recommendation. This is not only for the postnatal period. For women who need to formula feed or who are considering to formula feed, it is important to discussions are started during pregnancy and continued in the postnatal period.
Infant Feeding Alliance	Guideline	25	10	An assumption runs through the guidelines that early supplementation with formula will spell the end of breastfeeding. None of the evidence reviews dealt with this question, seeing it outside of the scope. It appears the committee have relied entirely on Baby Friendly guidelines, despite grading them low on quality. We would point to recent evidence from randomised controlled trials that has demonstrated that early limited supplementation with formula does not increase breastfeeding cessation (Flaherman et al., 2013, 2018b, 2019a; Straňák et al., 2016). Other recent evidence suggests modest supplementation of formula is not associated with earlier cessation of breastfeeding (Flaherman et al., 2019b).	Thank you for your comment. In finalising the guideline the committee addressed this point by editing a recommendation in the formula feeding section, which now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk.

Infant Feeding Alliance	Guideline	26	1	*We suggest that when supporting families to formula feed, the emphasis should be on what they need and should avoid being overly prescriptive about positions for holding a baby for bottle feeding. Recognising the risks of prop feeding, we query why this is not communicated to all parents regardless of their feeding intentions, because the majority of them will bottle feed at some point.*	Thank you for your comment. The committee did not make any changes in light of this because they feel it addressed by the fact there is a similar recommendation to provide information and advice about breastfeeding, including feeding positions. Advice about feeding positions is therefore not limited to formula feeding.
Infant Feeding Alliance	Guideline	26	3	Nowhere in your evidence reviews did you find evidence that parents who formula feed need info on how to bond with their babies. Nor did you find that skin-to-skin, eye contact and minimising the number of people feeding a baby are predictive of better outcomes. Your evidence reviews (Q) showed that parents are finding ways to survive the newborn period by sharing bottle feeding. We find it unconscionable that these guidelines problematise this and shame parents who make use of their support network by involving older siblings, grandparents and other close family members or friends to feed their babies. We would also appeal to common sense and state here: it is in fact easier and more comfortable to make eye contact with a baby while bottle feeding than while breastfeeding! We believe that this recommendation is simply stigmatising information lifted directly from Baby Friendly Initiative guidelines (which your evidence reviews rated low on quality, including for involvement of patients).	Thank you for your comment. You are right to highlight that we did not review the evidence on the benefits and harms of skin-to-skin contact for this guideline. However, we did look for, but did not identify, relevant evidence in relation to giving information about skin-to-skin contact and how that might impact emotional attachment. In the absence of evidence - and in accordance with the NICE methods manual - the committee therefore made consensus-based recommendations about promoting emotional attachment, both in the section on emotional attachment as well as in the section on support for formula feeding. The committee agreed to also mention skin to skin contact in the formula feeding section because unlike breastfeeding, skin to skin contact is not necessarily or routinely achieved. The wording of the recommendation avoids pressuring parents toward skin to skin contact during formula feeding, it merely states that encouraging skin to skin contact should be part of the support provided. Also on the basis of their

					experiential knowledge and in relation to supporting successful formula feeding the committee agreed it is important to discuss minimising the number of different people regularly feeding the baby and in response to your comment, they edited the recommendation to use those rather than the original words which mentioned 'keeping the number of people feeding the baby to a minimum'. Finally, the committee wished to highlight that they also recommend to provide advice and information on feeding positions for to parents who are breastfeeding so there is no implication that one approach is more or less comfortable than the other.
Infant Feeding Alliance	Guideline	26	6	As parents, we find the implication here, as well as its supporting rationale, deeply disturbing. Many of us benefited from sharing feeds with our partners and, in some cases, it was vital to safeguard our mental health. We recognise many of the experiences of the families cited in Evidence Review Q, where sharing the load of feeding was a way to survive the newborn period. We are horrified that the guidance appears to stigmatise and problematise partners feeding their own babies and enjoying it. We question whether these guidelines genuinely wish to support new families or are in fact aimed at increasing exclusive breastfeeding rates. We also question what advice should be given to parents, since the evidence reviews presented no data on how babies can be comforted and soothed. Most of us	Thank you for your comment. The committee agreed to remove the bullet point about 'other ways that partners can comfort and soothe…' and instead have edited an earlier bullet point which now refers to providing advice about ways - other than feeding - that babies can be comforted. This does not imply that formula feeding - whether by the woman or other family members - would not soothe or comfort the baby, simply that there are other, additional ways of doing this. The committee agree that health practitioners providing postnatal care for the woman and baby would be well positioned to have these discussions, which would be informed by their own professional experience as well as the experience of the parents themselves. Finally, there are specific recommendations in the guideline about promoting bonding and

				find ways to do this intuitively, based on our own experiences, personalities and in response to our baby's unique personality and temperament. We believe this is the stuff of evolving, nurturing, organic family attachments and cannot and should not be prescribed. Where there are considerable bonding difficulties (i.e., due to severe mental illness or developmental trauma/attachment-based disorders), this requires highly specialist assessment and intervention beyond the remit of universal primary care services.	emotional attachment. In the committee's view, referrals to specialist services prompted by concerns over emotional attachment would not take place within the first 8 weeks but they did make a recommendation that additional support in this regard may be needed by some parents, including (but not limited to) those who have experienced a traumatic birth and those with complex psychosocial needs.
Infant Feeding Alliance	Guideline	26	8	Parents are not in a position to make an informed decision about infant feeding because information about formula feeding and what to expect from breastfeeding is withheld antenatally. Nor are they given a balanced, accurate depiction of the absolute benefits and risks of infant feeding decisions. However, by the time they are thinking of switching from breastfeeding to formula feeding, they are likely to be in a distressing situation that is impacting their wellbeing and mental health, and this is not the time to be discussing risks and benefits of different options. While a mother is potentially struggling with excessive sleep deprivation, pain, mental health difficulties or a baby suffering the complications of under-feeding, it is vital that healthcare providers step back. Parents must be allowed to make a decision about whether to stop trying to breastfeed, in accordance with their own needs and priorities and without the pressure of a public	Thank you for your comment. The committee discussed your point and are still of the view that in light of the additional health benefits for women and babies from breastfeeding and in view of the enormous amount of information given during the antenatal period then information about formula feeding should be given to families who are thinking about (and therefore may still be undecided) or who need to formula feed. The committee feel their recommendations about the provision of information and support for formula feeding reflect the importance of practitioners being respectful, person centred, sympathetic and non-judgemental. That said, they did make some changes to the formula feeding recommendations, in light of yours and other stakeholder comments. For example one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially

				health agenda. We would be happy to offer the committee our experiences of the realities for many families, and to explain why for many of us, continuing exclusive breastfeeding was not a reasonable option.	formula fed alongside breastfeeding or expressed breast milk. There is also a recommendation about supporting parents in their decision making when they are considering supplementing breastfeeding with formula or changing from breastfeeding to formula feeding. In this sense the committee do feel they have addressed your point and demonstrated understanding and empathy with the experiences you describe.
Infant Feeding Alliance	Guideline	27	1	As parents, we find the idea of this information being presented without soliciting it to be insensitive, lacking in compassion and potentially coercive – putting pressure on women to be altruistic during potentially difficult circumstances. Also, to donate breastmilk requires introducing expressing into a woman's routine, which may add pressure at a difficult time.	Thank you for your comment. The committee's view and experience is that for some women who cannot breastfeed their baby for various reasons, donating milk to a milk bank may be a good option. The discussions around lactation suppression should follow the recommendations in the section (now renamed to) 'principles of care' which state that the discussion should be tailored to the needs and preferences of the woman, be sensitive, individualised, supportive and respectful.
Infant Feeding Alliance	Guideline	28	22	The guidelines perpetuate a position where feeding is firstly the mother's responsibility. While we recognise that breastfeeding disproportionately impacts women, as parents we take the view that feeding is the responsibility of all involved parents and guidance should take into account and address both. We also think conflating feeding with bonding is deeply unhelpful and not accurate. Parents are constantly responding to and interacting with their baby and their cues that they need feeding, to sleep, to be cuddled, to be played with or	Thank you for your comment. The committee agrees and have revised the text to say "or parent in the case of bottle feeding". We are not suggesting at all that feeding is the main way of bonding with the baby but responsive feeding can certainly be one of the natural ways of interacting and bonding with the baby, regardless of the mode of feeding. The definition we provide about bonding and emotional attachment do not mention feeding so we are not sure where this concern comes from.

				given space. It is wrong to give the impression that how a baby is fed is the be all and end all of healthy attachments and family relationships.	
Infant Feeding Alliance	Guideline	30	2	Given that the evidence reviews (P, Q, R, S) found no evidence for interventions to increase breastfeeding and were vague on what breastfeeding support involves, we suggest a good research recommendation would be: What interventions can help with common breastfeeding problems for all parents who want to breastfeed? As for parents of multiples, we think the question should be rephrased as what practical support they might need, with infant feeding and otherwise. Families with triplets will be especially likely to share care and support each other with feeding, possibly with additional family members' involvement. The idea of encouraging mothers of triplets to exclusively breastfeed shows a staggering lack of understanding of the realities and of basic compassion. However, if mothers of multiples wish to breastfeed, a realistic option would seem to be mixed feeding, which is not covered in these guidelines.	Thank you for your comment. Evidence review P identified a large body of evidence on interventions to start and maintain breastfeeding, however the research was inconclusive as to an intervention that would significantly increase breastfeeding rates. In view of the large body of evidence, the guideline committee didn't prioritise a research recommendation on interventions to increase breastfeeding. The guideline committee prioritised breastfeeding support for parents with twins or triplets as there was a paucity of evidence in this population. The purpose of the research recommendation on breastfeeding support for parents with twins or triplets is not to encourage or push parents to breastfeed, but rather if the parents chose to breastfeed that there are specific recommendations based on evidence to support parents, whether this is exclusively or in combination with formula.
Infant Feeding Alliance	Guideline	32	6	We would like to point out that it was in Baby Friendly facilities, or those working towards accreditation, that we experienced unsafe and coercive care, where staff seemed motivated to keep us exclusively breastfeeding at all costs. Many of us experienced readmissions with our babies for excessive weight loss, dehydration and	Thank you for your comment. The committee do feel the recommendations about formula feeding reflect the empathy and understanding they have for the kinds of experiences you describe. These recommendations are not based on the Baby Friendly Initiative but the committee are aware that it provides an important context within which this guideline will be

				jaundice in the first few days after discharge. We have since discovered rates of readmissions of this kind more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017). We would urge the committee to investigate Baby Friendly's safety data and what evidence they are using to base their guidelines upon, before assuming that they are the gold standard.	implemented. The committee believe that if the recommendations they have made are fully implemented then the types of experiences you describe would not occur and that consistency in this sense would be achieved.
Infant Feeding Alliance	Guideline	35	27	We find the language here deeply patronising. We question why the committee believes that women have trouble understanding information. We also question whether it is a healthcare professional's role to get women to be compliant, or simply to give information that then may or may not be taken on board. The goal should be to inform so that we can make our own decisions, not follow the advice and do as we are told!	Thank you for your comment. The committee agree to some extent with your point and in response have edited the text.
Infant Feeding Alliance	Guideline	45	29	Citation needed! We would point out that healthcare providers who denied our lived experience, encouraged us to keep breastfeeding despite distressing complications and delivered stigmatising policies around formula feeding had an adverse effect on our self-esteem. The committee may be interested in the psychological literature that highlights that the pursuit of high self-esteem can be problematic. To achieve it, people must feel special and above average. Needing to feel better than others to feel good about ourselves can lead to bullying, competitiveness and prejudice. Indeed, we	Thank you for highlighting this. The committee agreed to delete this sentence from the final version of the guideline. As you rightly point out it was not supported by the evidence reviewed.

				suggest that the quest to achieve self-esteem through breastfeeding may well be a key contributing factor to the conflict and sometimes viciousness that features in infant feeding discussions. That healthcare professionals could be contributing to the creation of a cultural environment in which a mother's self-esteem is contingent on her breastfeeding success should provoke self-reflection and soul searching. We propose that an ethos of compassion should be the bedrock of infant feeding policy and culture. In such an environment, the challenges and suffering that families experience as they feed their babies would be acknowledged without becoming a judgement on their identity or 'performance' as a mother or their relationship with their baby. Such a culture would recognise that having a baby is a tender and challenging time for most people. Far from being alone or abnormal in our struggles, or feeling stigmatised for our decisions, whatever they may be, we would see ourselves as a community, supporting and nourishing a diversity of families, each of whom navigates the joys and challenges of family life in unique ways. We also propose that in an environment where social comparisons and judgements are replaced with mutual respect, compassion and kindness, there would be more widespread acceptance of breastfeeding in public places and of older babies and children. And lastly, but by no means least, the emphasis in feeding babies would be on kindness – on	

				ensuring first and foremost that babies' nutritional needs are met and no baby or parent should ever suffer the fear and distress of an early readmission that could have been prevented. Families would feel able to feed their babies in whatever way best meets the physical and emotional needs of all family members.	
Infant Feeding Alliance	Guideline	47	14	As parents struggling with difficult, painful and exhausting breastfeeding experiences and thinking about stopping, we experienced reassurance and encouragement as gaslighting. Healthcare providers not acknowledging our lived experience and normalising our suffering had an adverse impact on our emotional wellbeing. In support of our own experiences, we point the committee towards a recent review of the Baby Friendly Initiative that showed adverse effects on mothers' wellbeing and mental health (Fallon et al., 2019). We suggest that there is a need for reflection on how the current policy of promoting exclusive breastfeeding and withholding information about formula feeding is affecting families.	Thank you for your comment. The committee do feel the recommendations about formula feeding reflect the empathy and understanding they have for the kinds of experiences you describe. In particular they feel that their recommendations about the provision of information and support for formula feeding reflect the importance of practitioners being respectful, person centred, sympathetic and non-judgemental. That said, they did make some changes to the formula feeding recommendations, in light of yours and other stakeholder comments. For example one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. There is also a recommendation about supporting parents in their decision making when they are considering supplementing breastfeeding with formula or changing from breastfeeding to formula feeding. In this sense the committee do feel they have addressed your point and demonstrated understanding and empathy with the experiences you describe.

Infant Feeding Alliance	Guideline	49	27	There was good evidence (Evidence Review T) that families wanted more information antenatally on formula feeding. However the committee rejected this finding and decided that this was not 'feasible'. Many of us went into the postnatal period unprepared for the breastfeeding problems we experienced and clueless when we needed to switch to formula. Unfortunately, the separation of the present guidance into two camps (Breastfeeding and Formula Feeding), the refusal to give all parents all the information antenatally and the complete absence of mixed feeding as an option means it is likely other parents will have similar experiences. Indeed, a recent review of the Baby Friendly Initiative in the UK found that women reported a sense of cluelessness about formula feeding and a lack of information and support available (Fallon et al., 2019).	Thank you for your comment. The committee discussed your point and are still of the view that in light of the additional health benefits for women and babies from breastfeeding and in view of the enormous amount of information given during the antenatal period then information about formula feeding should be given to families who are thinking about (and therefore may still be undecided) or who need to formula feed. The committee feel their recommendations about the provision of information and support for formula feeding reflect the importance of practitioners being respectful, person centred, sympathetic and non-judgemental. That said, they did make some changes to the formula feeding recommendations, in light of yours and other stakeholder comments. For example one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. There is also a recommendation about supporting parents in their decision making when they are considering supplementing breastfeeding with formula or changing from breastfeeding to formula feeding. In this sense the committee do feel they have addressed your point and demonstrated understanding and empathy with the experiences you describe.
Infant Feeding Alliance	Guideline	52	4	Your evidence reviews (Q, T) showed that many families are finding pragmatic ways to adjust to the demands of the postnatal period	Thank you for your comment. The committee reviewed the guideline in light of the points you make. They acknowledge that the

				and, in our words, 'survive it'. Like us, many of the families surveyed shared feeding responsibilities using bottles. Unfortunately, we feel the present guidelines undermine choices parents make around feeding. We feel that steering families down one feeding path and undermining the reasoning behind other choices is not helping them adjust to their new life, is outside the remit of healthcare providers and is not supportive. There are many ways to be a loving, nurturing family.	feeding recommendations were made in the context of the widely accepted health benefits of breastfeeding for women and babies. Nevertheless they do not feel they steer families down one single route or propose that healthcare professionals be unsupportive of decisions to formula feed. In particular they highlight that the recommendations about the provision of information and support for formula feeding reflect the importance of practitioners being respectful, person centred, sympathetic and non-judgemental. They also made some changes to the formula feeding recommendations. For example one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. There is also a recommendation about supporting parents in their decision making when they are considering supplementing breastfeeding with formula or changing from breastfeeding to formula feeding. In this sense the committee do feel they have addressed your point and demonstrated understanding and empathy with the experiences you describe.
Infant Feeding Alliance	Guideline	53	9	While the guidelines refuse to accept that exclusive breastfeeding is not a reasonable option for many families, while they refuse to celebrate the ways families are finding to cope in the postnatal period (including mixed feeding and sharing feeding responsibilities), while they downplay the severity of common	Thank you for your comment. The committee do feel the recommendations about formula feeding reflect the empathy and understanding they have for the kinds of experiences you describe. In particular they feel that their recommendations about the provision of information and support for

				breastfeeding problems, they are not taking into consideration each family's individual situation and needs. Reading these guidelines, we feel that, once again, families are being let down by the people we rely on to provide us healthcare at this most vulnerable time. The committee has failed to identify high-quality evidence that early supplementation can prevent morbidity, including high-quality randomised trials demonstrating that early limited supplementation can prevent readmissions (Flaherman et al., 2013, 2018b, 2019a; Straňák et al., 2016). We propose that it looks as though the committee are more concerned about breastfeeding rates than they are about feeding complications and their effects on babies and parents. The committee's own evidence review showed that women want information about all feeding methods but the committee concluded that this was not feasible. We look forward to the committee reconsidering its position and responding to the needs of parents, which their own evidence reviews identified.	formula feeding reflect the importance of practitioners being respectful, person centred, sympathetic and non-judgemental. That said, they did make some changes to the formula feeding recommendations, in light of yours and other stakeholder comments. For example one of the recommendations now states that practitioners should take into account that babies may be fully formula fed or partially formula fed alongside breastfeeding or expressed breast milk. There is also a recommendation about supporting parents in their decision making when they are considering supplementing breastfeeding with formula or changing from breastfeeding to formula feeding. In this sense the committee do feel they have addressed your point and demonstrated understanding and empathy with the experiences you describe. Finally, with reference to the studies you highlight, these do not fit the protocols for either the review about the effectiveness of breast feeding interventions or the review about information and support for formula feeding, which was a qualitative review.
Infant Feeding Alliance	Guideline	General	General	*References Ayers, S., Crawley, R., Webb, R., et al., 2019. What are women stressed about after birth? Birth 46, 678–685. https://doi.org/10.1111/birt.12455. Bass, J., Gartley, T., Kleinman, R., 2016. Unintended Consequences of Current Breastfeeding Initiatives. JAMA Pediatr.170 (10):923–924. https://doi.org/10.1001/jamapediatrics.2016.1529. Dennis, C.L., Jackson, K., Watson, J.,*	Thank you for providing these references in relation to your comments. We have checked and none of the references meet the inclusion criteria for the evidence reviews in the guideline. Studies which weren't located in the search and didn't meet the population, intervention, comparator, or study design criteria set out in

				*2014. Interventions for treating painful nipples among breastfeeding women. Cochrane Database Syst. Rev. 12, CD007366. https://doi.org/10.1002/14651858.CD007366.pub2. Fallon, V., Harrold, J., Chisholm, A., 2019. The impact of the UK Baby Friendly Initiative on maternal and infant health outcomes: a mixed-methods systematic review. Matern. Child Nutr. 15 (3), e12778. https://doi.org/10.1111/mcn.12778. Flaherman, V.J., Aby, J., Burgos, et al., 2013. Effect of early limited formula on duration and exclusivity of breastfeeding in at-risk infants: an RCT. Pediatrics 131 (6), 1059–1065. https://doi.org/10.1542/peds.2012-2809. Flaherman, V.J., Schaefer, E.W., Kuzniewicz, M.W., et al., 2018a. Health care utilization in the first month after birth and its relationship to newborn weight loss and method of feeding. Acad Pediatr 18 (6), 677–684. https://www.academicpedsjnl.net/article/S1876-2859(17)30566-1/fulltext. Flaherman, V.J., Narayan, N.R., Hartigan-O'Connor, D., et al., 2018b. The effect of early limited formula on breastfeeding, readmission, and intestinal microbiota: a randomized clinical trial. J. Pediatr. 196, 84–90. https://doi.org/10.1016/j.jpeds.2017.12.073*Flaherman, V.J., Cabana, M.D., McCulloch, C.E., et al., 2019a. Effect of early limited formula on breastfeeding duration in the first year of life: a randomized clinical trial. JAMA*	the protocols for any question in the guideline - Ayers 2019, Bass 2016, Dennis 2014, Fallon 2019, Flaherman 2019a, Flaherman 2019b, Goldsmith 2013, Jafaar 2016, Keeble 2017, Moore 2016, Murase 2017, Ng 2019, Tarcan 2005, Wilson 2018 Studies which were identified in the search and didn't meet the population, intervention, comparator, or study design criteria set out in the protocol at title and abstract level: Flaherman 2013 (evidence review Q), Flaherman 2018a (evidence review P), Flaherman 2018b (evidence review P), Stranak 2016 (evidence review Q). The UNICEF 2014 guideline on formula feeding was not included in any of the reviews because it didn't meet the population, intervention, comparator, or study design criteria set out in the protocols for any question in the guideline. However, aware of the support and guidance provided by UNICEF and BFI the committee made several references in the underpinning rationale to information and advice they have published, for example on responsive feeding and on safer sleeping.

				Pediatr 173 (8), 729–735. https://doi.org/10.1001/jamapediatrics.2019.1424. Flaherman, V.J., McKean, M., Braunreuther, et al., 2019b. Minimizing the relationship between early formula use and breastfeeding cessation by limiting formula volume. Breastfeed. Med. 14 (8), 533–537. https://doi.org/10.1089/bfm.2019.0055. Goldsmith, J., 2013. Hospitals should balance skin-to-skin contact with safe sleep policies. AAP News. 34 (11) 22. Available from: https://www.aappublications.org/content/34/11/22. Accessed date: 27 November 2020. HSIB, 2020. National Learning Report Neonatal collapse alongside skin-to-skin contact. Available from: https://www.hsib.org.uk/documents/238/hsib-national-learning-report-neonatal-collapse-alongside-skin-to-skin-contact.pdf. Accessed date: 27 November 2020. Jaafar, S., Ho, J., Lee, K., 2016. Rooming-in for new mother and infant versus separate care for increasing the duration of breastfeeding. Cochrane Database Syst. Rev. 8, CD006641. https://doi.org/10.1002/14651858.CD006641.pub3. Keeble, E., Kossarova, L., 2017. Focus on: Emergency hospital care for children and young people. Available from: https://www.nuffieldtrust.org.uk/files/2018-10/1540142848_qualitywatch-emergency-hospital-care-children-and-young-people-full.pdf. Accessed date: 27 November 2020. Moore, E.R., Bergman, N., Anderson, G.C.,	

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				https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/02/Guidelines-on-providing-information-for-parents-about-formula-feeding.pdf. Accessed date: 27 November 2020. Wilson, J., Wilson, B.H., 2018. Is the "breast is best" mantra an oversimplification? J. Fam. Pract. 67 (6), E1–E9. Available from: https://www.mdedge.com/clinicianreviews/article/166932/pediatrics/breast-best-mantra-oversimplification. Accessed date: 27 November 2020.	
La Leche League GB	Evidence Review A	General	General	The effect of the length of hospital stay on breastfeeding depends on many factors, including the quality of breastfeeding support given in the hospital, which (despite training) can vary greatly between staff members. There is also a shortage of funding for breastfeeding specialists on the wards and in society in general. The type of birth and drugs administered to the mother during labour and after birth can also affect breastfeeding, as well as the baby and mother's behaviour. The baby's anatomy can also be affected and have an impact on breastfeeding outcomes. The guideline mentions that the decision about when a woman should be discharged should be made taking into account her preference, which is good in theory. Just because she is 'medically fit' doesn't mean she is ready to go home. We need to look at the whole picture. A woman who is anxious and overwhelmed by the birth and adjustment to motherhood may need a longer stay and	Thank you for your comment. We agree that just because a woman is "medically fit" doesn't mean she is ready to go home, this is why the committee have emphasised the importance of the woman's needs, preferences, and support available to her. Furthermore, the committee recognised that the woman's psychological and emotional wellbeing are as important alongside their physical health, therefore linked to the recommendations to assess the woman's psychological and emotional wellbeing in the recommendations about prior to discharge.

				more support in hospital. Humane care of women after such a monumental event as birth is in the interest of all of society. Despite the recommendation in this guideline, the reality in hospital is often that women are discharged too quickly, as beds are needed for other patients. For example, after my third C-section, I wanted to stay in hospital for longer (3,4 or 5 nights), but it was very clear that I would not be able to stay for more than two nights. Staff members were great for the first 24 hours, but after that there seemed to be much less compassion and I could sense they wanted me out, almost as though they thought I was 'taking advantage' of the system by still being there. Breastfeeding was very painful (along with my wound) and slow to get going. My baby became jaundiced and we had to have a stressful and painful journey back into hospital to have him checked on day 4. The time of year can also have an effect on how long a woman feels she would like to stay in hospital. In winter, it can be harder to go home and be alone with a baby than in summer. The effects of a woman's length of hospital stay on her mental health depend on what the woman's wishes are. For example, after my first C-section in the spring, I was happy to go home after two nights. After my third C-section in the winter, with two other young children at home and breastfeeding being very painful, I felt I needed to stay in longer, but I was considered medically fit, so it was frowned upon.	

La Leche League GB	Evidence Review D	General	General	There is a dramatic drop off of breastfeeding rates by six weeks of age. This happens during the time parents are under the care of their Health Visitor. This is a critical stage for women/parents to have routine care that normalises breastfeeding where they have easy, open access to specialist breastfeeding support, breastfeeding groups and peer supporters. Perhaps a re-definition of the role of the Health Visitor (a role which originated after the first world war) would more appropriately serve the needs of women and babies at the present time. These needs include psychological and emotional support to cope with the hard and important work of parenting in a society that does not value mothering. Mothers and babies also need skilled, open access breastfeeding support (for example, in some states in America all breastfeeding women have a Lactation Consultant appointment at 6 weeks)., We know that women in this country are not always getting the breastfeeding support they need from their Health Visitor, GP or midwife (professional health services) because the La Leche League helpline received 400 calls in October 2020. Not all of these calls were answered by our volunteer breastfeeding counsellors, because, as unpaid volunteers, often with their own young children to care for and to breastfeed, they have to prioritise their own families. Women and mothers are being let down on every level here. It is devastating that so many women reached	Thank you for your comment. The committee agree with you about the vital importance of the health visitor role including the provision of support with infant feeding. There are a great deal of recommendations in the guideline about the help, support and information that health professionals should give to women and their partners about infant feeding, including breastfeeding. These have been designed to improve the level, content and continuity of help given to women and their partners, particularly during routine contact with health professionals.

				out for support and didn't get it. Why does it fall to other unpaid women to provide a service, when there could be a fully funded and resourced service that is better able to meet the needs of mothers?	
La Leche League GB	Evidence Review M	General	General	I am delighted that the word 'Benefits' comes before the word 'Harms' in this title. It marks a big step forward in the way we can support mothers and babies to sleep in a way that suits them best. The outcomes of the studies quoted seem to reflect the instinctive wisdom of mothers across the world and across the ages, that bedsharing is the most natural, logical and practical way of meeting a baby's needs and breastfeeding at night. As mothers, we know that our infants will be better attached, will breastfeed for longer, will be more secure and healthier with lower stress levels if they sleep close to us at night. All we have to do is listen to our baby and our body. We know that breastfeeding releases oxytocin in both mother and baby, which makes us relaxed. This is nature's way of making breastfeeding a pleasant and restful experience. It is a relief to see that 'official' guidelines are finally catching up with this inherent maternal knowledge, so that families who choose to bedshare will hopefully not be shamed or demonised any more by health professionals giving blanket bans based on subjective outlook, inadequate evidence, social taboo or negative judgement of mothers and mothering. Back in 2007 I was told by my Health Visitor that my son would have an	Thank you for your comment and providing this information

				'attachment disorder' if he slept in my bed. This is a shocking thing to say to a new mother, trying hard to follow her instinctive mothering behaviour and quite frankly trying to survive on little sleep whilst also meeting her baby's needs for comfort and closeness. The Unicef Baby Friendly Initiative promotes close and loving relationships and we cannot just switch those off because it is night time.	
La Leche League GB	Evidence Review N	General	General	I am delighted that the results of this analysis correspond to the research done for the LLL Publication 'Sweet Sleep', where the Safe Sleep Seven are identified for safe co-sleeping. LLL has long acknowledged that co-sleeping is a useful parenting tool and is what most babies want. Also that mothers who co-sleep are more likely to carry on nursing for longer, which reduces the risk of SIDS. LLL also acknowledges that when babies sleep on their own, for longer periods, more deeply and with less breastfeeding contact during the night, this can increase the risk of SIDS, lead to stress hormones rising, and brain development and attachment can be impaired. The term 'breast-sleeping' has been coined to describe a mother-baby breastfeeding and bed-sharing dyad. Please see below the references to evidence our comments above: 1. Reasons for mother-infant bed-sharing: a systematic narrative synthesis of the literature and implications for future research Trina C Salm Ward 2. An Integrated Analysis of Maternal-Infant Sleep, Breastfeeding, and Sudden Infant Death Syndrome Research	Thank you for your comment and for the supporting information.

				Supporting a Balanced Discourse Kathleen A. Marinelli, Helen L. Ball, BSc (Hons), MA, PhD, James J. McKenna, MA, PhD et al. 3. Bedsharing and Breastfeeding: The Academy of Breastfeeding Medicine Protocol #6, Revision 2019 Peter S. Blair, Helen L. Ball, James J. McKenna, Lori Feldman-Winter, Kathleen A. Marinelli, Melissa C. Bartick et al. 4. Bed-Sharing in the Absence of Hazardous Circumstances: Is There a Risk of Sudden Infant Death Syndrome? An Analysis from Two Case-Control Studies Conducted in the UK Peter S. Blair ,Peter Sidebotham,Anna Pease,Peter J. Fleming	
La Leche League GB	Evidence Review O	General	General	When a mother feels respected, acknowledged and supported practically, emotionally and financially, (i.e. when we as a society care for mothers), she can be in the best place to provide the most attentive care for her baby. The importance of supporting mothers and babies cannot be underestimated and is of direct benefit to the whole of society, including those babies who have no voice yet, but who will go on to be the next generation of leaders. It is very positive that this evidence review recognises that emotional attachment for our very dependent infants and children is a firm foundation for life, health and wellbeing. There seems to be an omission of the mention of breastfeeding in this context. Infants are born biologically expecting to breastfeed. LLL recognises that breastfeeding is the most effective way of responding to a baby's needs and that a	Thank you for your comment. The evidence review looked at interventions which started antenatally or within the first 8 weeks after birth and emotional attachment outcomes were measured at 12-18 months of age. Therefore, breastfeeding toddlers aged 12-18 months of age as an intervention are outside the remit of this question.

				baby's need for his mother is as important as his need for food. The babies in this study were 12-18 months. Many mothers find that breastfeeding a toddler can be the easiest way to help them regulate their emotions and to connect to a feeling of security after some time apart. The WHO recommends breastfeeding for a minimum of 2 years or more. A breastfeeding toddler is unlikely to have an insecure attachment.	
La Leche League GB	Evidence Review P	General	General	The fact that, out of the four interventions listed, the evidence didn't show that one of them had a particularly big impact on increasing breastfeeding rates, shows that supporting women to breastfeed is best done on an individual and societal basis. A woman needs one to one care and specialist support. The things which make a difference to whether she can breastfeed are often unscientific, unmedical and possibly "uneconomic" too: genuine, heartfelt, non judgemental support, company, respect, spending time with the mother without rushing her, walking alongside her with patience and compassion while she learns and builds her confidence, and genuinely caring if breastfeeding works out. This is why peer support and mother to mother support can be so positive. She also needs easy open-access to breastfeeding specialists and groups. It's also crucial to recognise that the societal level is very important and that there is much that could be done at a government level to change the culture in this country. There is also a cost in terms of women's	Thank you for your comment, with which the committee are in general agreement. The kinds of issues you raise link in with the findings of the qualitative reviews on breastfeeding facilitators and barriers and breastfeeding information and support. This is reflected in the recommendations made by the committee about planning and managing babies' feeding, particularly the recommendations about the role of the healthcare professional supporting breastfeeding and those under the sub heading of 'supporting women to breastfeed'. We acknowledge the additional intangible costs regarding women's and babies' mental health and wellbeing resulting from women wishing to breastfeed who are unable to, and we have added this point on page 238 of evidence report P. The committee considered the strengths and limitations of the economic analysis when making recommendations, and took into account the areas where benefits and cost-savings from breastfeeding may have been overestimated, and areas where these may have been

				mental health, babies' well-being, and the impact of maternal attachment behaviour for those who are unable to breastfeed for as long as they wanted to because of societal barriers and a lack of skilled support. This should be taken into account when looking at the economics.	underestimated. See pages 91-92 for a summary of the committee's discussion regarding representation of costs and benefits of breastfeeding in the guideline economic modelling.
La Leche League GB	Evidence Review Q	12	012 – 029	This evidence outlines well the impact breastfeeding and mothering have on women's tiredness and ability to manage day to day in the separate and isolated nuclear bubble she lives in in our society. Our society has an unrealistic expectation (which has been espoused by health professionals for decades) that newborn infants, toddlers and young children should be able to sleep on their own (separated from parents) and without waking up at night. The shame, exhaustion and negative judgment a mother feels when her baby doesn't 'sleep through' comes as a shock. She is not expecting her baby to need her even more at night than during the day. It used to be seen as taboo and socially unacceptable to co-sleep with your baby (an extremely unhelpful environment and society for new parents and babies) and it is now more openly discussed, but still frowned upon. So rather than accepting that the normal infant sleeps next to his mother and breastfeeds frequently, ('breastsleeping') a woman will often feel that rather than feel like an outsider, she would rather be seen as 'normal' and sleep train (once she stops feeding at night, her milk supply will decrease), stop breastfeeding,	Thank you for your comment.

				bottle feed. **********When a woman becomes a mother she has to deal with the shock of realising what a big job it is, and simultaneously how invisible she feels, while she is putting her heart, soul, body and mind into raising a human, 24/7. *The work of mothering is often hidden or judged harshly by others. Women are also shocked by how dependent their babies are on them, and in turn by how dependent they themselves become and how vulnerable they feel in their tiredness and overwhelming emotions of new motherhood. In a society that values independence over care, this can feel very jarring and women will resort to ways of trying to get their independence back.	
La Leche League GB	Evidence Review Q	18	004 - 012	"Low quality evidence from 1 study (n=8) reported on this sub-theme. Several women talked about a sense of pride in being able to nourish their baby with their own body and saw it as an essential part of motherhood. On the other hand, difficulties with breastfeeding were seen as a threat to maternal identity and this meant that women felt obliged to persist in trying to overcome obstacles to successful breastfeeding. Women struggled every day to make breastfeeding work, even if this meant forgoing their own needs." Perhaps it could be noted that many women feel a strong instinctive and hormonal drive to breastfeed their infant and that breastfeeding is the physical demonstration of love in this intimate relationship. A woman knows instinctively how vital this early bond of love	Thank you for your comment. The narratives for the evidence statements are based on information extracted from the included studies in this review.

				and nourishment is and so she is prepared to forgo her own needs until her baby has grown and is less dependent on her. A mother in this scenario needs to be mothered herself. Societies where women mother in family and community groups and have a 'laying in' period are able to meet the needs of mothers and babies organically. Dependence dynamics ebb and flow, which means even though a mother may struggle to meet her own needs and that of her baby at the same time, her needs can be met by her family while she meets the needs of her baby. This is how we are designed to parent, in a caring and cared-for setting, and this set up makes it easier for women to breastfeed and have good mental health.	
La Leche League GB	Evidence Review Q	20	001 - 010	"High quality evidence from 5 studies (n=243) reported on this sub-theme. Among the main breastfeeding problems was a perceived lack of satiation by the baby. Formula milk was used to top up breastfeeds within the first few days after the birth. The main reasons for introducing formula milk included a very unsettled baby, which caused exhaustion and anxiety. A discontented and unhappy baby made women doubt their ability to breastfeed effectively." Women held the idea that formula-fed babies fed less frequently, slept for longer and were generally more settled and content. On the other hand, breastfeeding women felt confident about producing and delivering enough milk when their baby was settling between feeds.	Thank you for your comment. The narratives for the evidence statements are based on information extracted from the included studies in this review.

La Leche League GB	Evidence Review Q	20	032 - 041	"Moderate quality evidence from 3 studies (n=198) reported on this theme. Women were confused and concerned about the irregularity of feed frequencies, particularly at night. Women talked about 'relentless feeding'. Breastfeeding mothers were aware of looking for feeding cues. However, the baby not settling was seen as the baby needing to be fed which resulted in them offering the breast and therefore perpetuating the feeling of constantly feeding. Women wanted to produce a 'good baby' with good habits and part of this involved limiting his other demands. Women described concerns relating to the baby playing at the breast or using the breasts as 'dummies', for comfort, or for falling asleep. Formula milk was seen as a solution to promote 'normal' newborn behaviour. "As breastfeeding counsellors, we find that many mothers need reassurance about 'normal' new-born behaviour and that in our society, this knowledge has been lost. There are often totally unrealistic expectations around attachment behaviour of infants and feeding frequency which undermine a woman's mothering and set her up to fail. This is combined with a lack of honouring and placing value on mothers and the incredibly hard and important work they do. Our society sees mothers and the work of mothering as 'less than'. It does not value care work. This is an outmoded and harmful view because care work, though unpaid, is the core of families and community. The government	Thank you for your comment. The narratives for the evidence statements are based on information extracted from the included studies in this review.

				sees mothers as 'inactive economic units'. There is a vested financial interest in separating mothers from their babies to get them back to work and outsourcing the mothering work as soon as possible. This skews women's expectations around the work of mothering, which is seen as less important than paid work outside the house, when in fact it is the most important job a woman can do.	
La Leche League GB	Evidence Review Q	General	General	. "level of support from family and friends . breast-related health (for example, women may have mastitis, breast engorgement, cracked nipples, breast augmentation). accuracy of information . emotional wellbeing. amount of sleep. time available. pain." This question is only addressed at parents, and this evidence reflects well the breastfeeding barriers that parents experience. However parents, doing the work on the ground and immersed in the culture, can't always see the all barriers. There are also important political and social barriers to breastfeeding which are not included here. This guideline outlines well the complex issues and lack of support facing breastfeeding women.	Thank you for your comment. Political and social barriers to breastfeeding were not identified as themes in the included studies for evidence review Q, and so are not included in the evidence review. However, the committee agrees with this and for example discussed that one of the reasons that evidence review P did not find clinical interventions to be particularly effective in improving breastfeeding rates is that there are issues and barriers beyond clinical practice that affect breastfeeding, including societal and public health issues. This discussion is captured in evidence review P.
La Leche League GB	Evidence Review R	General	General	The evidence presented here shows that the Unicef BFI Infant Feeding Tool is a good predictor of breastfeeding difficulties and that it is important that all breastfeeding women have a full feed observed in hospital before they go home. I agree with this and would like to emphasise that skilled staff members need to have the time to observe a feed. The	Thank you for your comment. We acknowledge that breastfeeding difficulties can arise after the first 24 hours and have recommended another observation within a week be conducted. In terms of some staff members not being as knowledgeable others about what to look for in a good feed, the recommendations state what knowledge the

				only issue here is that some staff members are not as knowledgeable as others about what to look for in a good feed, also that the feeding in the first 24 hours tends to be instinctive and go well. Difficulties can often arise after this period, when parents are at home on day two or on day three, when breastfeeding becomes more of a learnt skill for the mother and the baby. This is also when the milk comes in, which can cause new difficulties with breastfeeding.	healthcare professionals giving breastfeeding support should have.
La Leche League GB	Evidence Review S	21	001 – 009	"High quality evidence from 6 studies (N=842) reported on this theme. Women valued encouragement and a friendly and non-judgemental approach which made them gain confidence, instil calm and sustain their hopefulness through reassurance and praise. It was important for women to know that they were able to access trusted help. The approach should also be non-dogmatic and realistic. All of this enhanced women's self- esteem and self-efficacy to continue breastfeeding. Support that only focused on the technical aspects of breastfeeding in an authoritative manner, rather than valuing the relationship with the woman, still occurred in some situations." La Leche League Leaders are all trained to relate to the women they support in an empathetic way and to meet each woman where she is on her breastfeeding journey. We have very positive feedback from women who appreciate our approach.	Thank you for your comment. It is encouraging to hear that La Leche League GB are supporting women who are breastfeeding at every stage of their journey.

La Leche League GB	Evidence Review S	21	010 – 015	“Moderate quality evidence from 4 studies (N=104) reported on this theme. Some women felt pressured by some professionals, and some commented that healthcare professionals seemed focused on meeting some targets. As a result, women experienced feelings of failure and alienation, and dismissed their advice as unrealistic.” Feeling ‘pressure’ to breastfeed can be significantly worse when women are told to breastfeed, yet there are no adequate support structures to help them to do so. Also, it doesn't help if the person giving the support isn’t genuinely invested. This needs more funding at government level so that women and babies are not being let down.	Thank you for your comment. Unfortunately, funding of breastfeeding support at government level is outside the remit of this guideline.
La Leche League GB	Evidence Review S	22	027 - 035	“Moderate quality evidence from 2 studies (N=71) reported on this theme. Women felt that peer supporters were mothers “like them” which enabled connections based on shared understandings. Peer supporters provided flexible and non-judgemental support based on women’s circumstances. Peer supporters gave their time and reassurance and according to women, they had personal qualities such as being reliable, ‘dedicated to what they do’, ’enthusiastic’, ‘good at talking to people’, ‘friendly’ and ‘approachable’'. Women explained that relationships with peer supporters were based on trust.” To build a robust, working peer support system, it would be helpful to pay peer supporters (like they do in some parts of America) in recognition of the positive role they have in supporting women.	Thank you for your comment. We acknowledge the important role of peer supporters in breastfeeding, however their payment is outside the remit of this guideline.

La Leche League GB	Evidence Review S	22	040 – 045	"High quality evidence from 4 studies (N=263) reported on this theme. Breastfeeding groups led to mutually supportive relationships. Women could share their experiences and gain information from others. Knowing that others had faced similar issues reinforced women's motivation and confidence to continue breastfeeding. This helped them to think of strategies to sustain breastfeeding." LLL agrees with this and hopes we can get back to offering in person support via our groups soon. "Some women blamed themselves and underestimated the importance of their own needs considering that midwives were very busy, and this made them reluctant to call for telephone support."	Thank you for your comment.
La Leche League GB	Evidence Review S	27	001 – 007	"Moderate quality evidence from 2 studies (N=32) reported on this theme. Some women found asking for help difficult and struggled on until they gave up breastfeeding. Many women knew that help was available and had the phone numbers that should be called to receive support from midwives, health visitors or voluntary organisations. However, many women did not access support during difficult times. The majority of women waited for help to be offered. Women often had difficulty explaining the reason why they had not sought help and blamed themselves."	Thank you for your comment.
La Leche League GB	Evidence Review S	27	008 – 010	"Very low quality evidence from 1 study (N=11) reported on this theme. Some women would rather not rely on someone else for support, in case that person lets them down." An unsympathetic, rushed	Thank you for your comment. It is encouraging to hear that La Leche League GB are supporting women who are breastfeeding at every stage of their journey.

				breastfeeding support person can make a woman feel hopeless or that she has done something wrong. "High quality evidence from 2 studies (N=49) reported on this theme. Women who actively sought help were more self-confident and often had experience communicating with unknown people through their work. Other women found it difficult to initiate contact with people they did not know well and to admit that they were having difficulties. One woman described her lack of confidence when explaining why she did not go to a breastfeeding clinic." In a society that values independence and fears dependence, many women find it hard to ask for support or feel they have failed if they need to. We need to make women and girls more familiar with the idea that they will need to be mothered and cared for when they are going through the transition into motherhood. i.e. we need a more compassionate, woman and child-friendly society at all levels. At LLL we often support women who have been breastfeeding for over a year and we recognise that breastfeeding mothers often find support and contact at that stage as valuable as early support, sometimes even more valuable as they will be in the minority of breastfeeding mothers by then.	
La Leche League GB	Evidence Review S	General	General	"The review question: What information on breastfeeding do parents find helpful?" The evidence presented here reflects very well the issues that women can face with the breastfeeding support they receive. One	Thank you for your comment. Information on breastfeeding including delivery were included in this review question, however no themes on information delivery on breastfeeding were identified in the included

				element that is perhaps not addressed is that it is not just the information or support given that has an impact on how the woman feels and whether she continues to breastfeed, but it is the person or organization giving the information that makes a difference. People remember how you made them feel, not what you said. So it is important that the support comes from someone who genuinely cares about and is personally invested in breastfeeding going well. As our mainstream society is a bottle feeding culture, the breastfeeding support a woman gets from within the mainstream (GP, Health Visiting Team, Midwife) is often not as effective as the breastfeeding support a women can get from a specialised breastfeeding organization (LLL, NCT, ABM, BFN) or a specially qualified Lactation Consultant or Breastfeeding Counsellor, who has studied in that branch of care. The evidence presented (see below) reflects exactly what has happened in Kent. There was a third sector Community Interest Company working alongside the Health Visiting Team to run breastfeeding groups and peer support training programmes. It was a mother-friendly system where there was open, local access to peer support, breastfeeding counsellors and Lactation Consultants. The group meetings were environments where breastfeeding was genuinely the norm (the people who ran it had breastfed themselves), it was deeply valued and genuinely welcome regardless of the age of the baby/child.	papers. Thus no specific recommendations were made with regards to specialist breastfeeding organisations or a specially qualified lactation consultant.

				When the Health Visiting Team took over the running of the groups, they became more clinical, less open and supportive environments, which no longer attracted a community of breastfeeders and numbers dropped. This may be in part also because attachment parenting, baby wearing and co-sleeping often goes hand in hand with breastfeeding and these parenting tools do not always feel welcomed by Health Visitiors. So the busy group I had run before was often empty, and the quality of the breastfeeding support suffered as it was seen as a more technical issue to be 'solved'. Rather than drawing in breastfeeding women who wanted company and support, it was mainly women who happened to be there for baby weighing anyway who were directed to the group. Unicef BFI for Health Visiting standards guidelines state that the best breastfeeding care can be given to women when they collaborate with Third Sector organisations and it is true that this has been reflected in what has happened in Kent (prior to Covid).	
La Leche League GB	Evidence Review S	General	General	The peer supporters having a positive impact on mother's mental health was mentioned in the Unicef BFI conference by the Camden feeding leading based on feedback from mothers themselves who said that it wasn't necessarily just about the feeding support but also, "the care and attention was amazing", "I feel better having spent time here", "super sensitive and encouraging non-judgemental advice", "Kindness, understanding, help and listening". A Health	Thank you for your comment. Evidence review S identified the positive impact that peer supporters have when supporting women to breastfeed and recommendations were made in view of this in the guideline.

				Visitor commented that she could see that the interaction with the peer supporters relieved anxiety and increased maternal confidence. It made an observable difference. Generally the positive impact peer supporters have on mental health isn't recognised widely enough.	
La Leche League GB	Guideline	16	General	Bedsharing: Was formula-feeding considered as a risk factor in the evidence review? I couldn't see feeding method included in the evidence review. Should formula-feeding be included in 1.3.13 as a reason to not bedshare?	Thank you for your comment. Formula feeding was not considered as a potential risk factor in the review and the evidence about this was thus not reviewed.
La Leche League GB	Guideline	20	007 - 009	Under "acknowledge the …impact of feeding choices", add 'infant and maternal health' as a reason to include for feeding choices (the health of mum and baby is impacted by feeding choices, too, and should be acknowledged equally).	Thank you for your comment. We have revised this text slightly to be more clear about acknowledging the concerns that parents might have about feeding options. Some parents might have concerns around how their feeding options impact the health of the baby or the mother, but these, we feel, are covered by the subsequent sections where breastfeeding and formula feeding are discussed.
La Leche League GB	Guideline	020 - 021	General	List of topics to discuss should include: • Developmental benefits to baby • Emotional and psychological benefits to mother and baby	Thank you for your comment. The list is not attempting to be exhaustive but covers some of the main established benefits of breastfeeding.
La Leche League GB	Guideline	23	30	CA clarification on what 'the information given may change' means (as appropriate to baby's development? i.e. starting solids?) is needed. The line should include not only that the information may change but *how* it may change and what parents can look out for.	Thank you for your comment. The committee discussed the point you make but did not change this part of the recommendation because they felt it was already clear that information and advice will change as the baby grows, necessarily being slightly different according to their stage or age.

La Leche League GB	Guideline	25	005 - 011	Add a point about how to choose which formula, emphasising that all infant formula meets the same regulations and standards, and that more expensive does not mean 'better'.	Thank you for your suggestion. The committee feel this is adequately addressed by the recommendation for health care practitioners to tell parents that first infant formula is the only formula milk that babies need in the first year of life. In addition there is a recommendation that for parents who formula feed, health care professionals should have a one to one discussion about safe formula feeding.
La Leche League GB	Guideline	25	010 - 011	Women who are trying to establish breastfeeding should be given information on how to maintain an adequate milk supply while supplementing with formula feeding, as well as clear guidance on when and how they can safely transition back to exclusive breastfeeding.	Thank you for your comment. The committee agreed with your point and edited the recommendation so it now refers to the provision of formula feeding information about how to maintain adequate milk supply.
La Leche League GB	Guideline	25	General	To be consistent with section 1.5.14 on breastfeeding, the formula feeding section starting at 1.5.17 should also include: A practitioner with skills and competencies in 'alternative milk feeding' management i.e. the practitioner has skills in paced bottle feeding, syringe feeding, cup and spoon feeding.	Thank you for your comment. The committee were unable to make these references because the evidence reviews only focussed on breast feeding and formula feeding.
La Leche League GB	Guideline	25	General	Could this be included in 1.5.17 to avoid repetition? Perhaps starting 1.5.18 and 1.5.20 with a statement that both written and face-to-face support should be given?	Thank you for your comment. We are not entirely sure what is being suggested and we have not made a changed these.
La Leche League GB	Guideline	26	001 – 002	Positions for bottle-feeding a baby should include side-lying under 6 weeks.	Thank you for your comment. This level of detail has not been included in the recommendation.
La Leche League GB	Guideline	26	17	Self-help advice should include information on early warning signs of engorgement, blocked ducts, mastitis and what to do.	Thank you for your suggestion, in response to which the committee added that a topic to be discussed in this context should include

					'when to seek help'. They also highlight that symptoms and signs of mastitis are covered elsewhere in the guideline.
Lactation Consultants of Great Britain	Evidence Review K	17	9	'baby being allergic to breastmilk' - this is not accurate: allergies are usually due to proteins from mother's diet present in breastmilk as opposed to the breastmilk itself. This indication for lactation suppression is not mentioned anywhere else in the guidance unlike the other indications, so is it needed?	Thank you for your comment. We have deleted "baby being allergic to breastmilk" from the discussion section.
Lactation Consultants of Great Britain	Evidence Review Q	27	27	There have been learning outcomes created by Unicef's Baby Friendly Initiative for undergraduate students in Medicine, Dietetics, and Pharmacy which address the stated topic areas. The leaning outcomes however, are geared towards universities implementing them into their specific curriculum.	Thank you for your comment.
Lactation Consultants of Great Britain	Evidence Review S	34	36	Reference to faltering growth guidelines is too general. Concerned that this recommendation doesn't address mothers choosing to mix feed (breast and formula) as a life style choice and not because their baby needs to gain weight. Does it need to be more specific in terms of the management of supplementary feeding as opposed to advantages and disadvantages of combination / mixed feeding?	Thank you for your comment. The recommendation has been amended to say that supplementary feeding with formula milk may sometimes, although not commonly, be clinically indicated, with a cross-reference to faltering growth guideline. In response to stakeholder comments a new recommendation has been added to the guideline under formula feeding to support women who are considering combination feeding or switching from breastfeeding to formula feeding, rather than discussing advantages and disadvantages.
Lactation Consultants of Great Britain	Evidence Review T	18	46	First infant milks are nutritionally similar as they have to follow strict guidelines on composition. Instead, guidance around the	Thank you for your comment. The committee agree with you about the importance of interpreting formula marketing claims.

				interpretation of marketing claims would offer reassurance to parents choosing to formula feed.	However this specific issue is outside the remit of the review question so the committee did not have the basis on which to make recommendations about interpreting marketing claims. They did however recommend that discussions with parents who formula feed should cover safe formula feeding and they should be given written, digital, or telephone information to supplement face to face support for formula feeding.
Lactation Consultants of Great Britain	Guideline	4	13	This is a very simple statement but it depends on so many factors and we must recognise that a health care professional cannot know by looking whether a single feed has been 'effective' – by what are they to judge? In our experience is very unlikely that a maternity staff member would have time to stay to observe the mother and baby through an entire feed. There are so many ways in which effective bottle and breast feeding are different, and the effective feeding of expressed colostrum would be different again.	Thank you for your comment. We have now added a definition of 'effective feed' to the 'Terms used in this guideline' section and a direct link to this definition within the recommendation. Assessment and support for feeding continues in the subsequent postnatal contacts but in this section we wanted to highlight that feeding is considered before transfer to come care.
Lactation Consultants of Great Britain	Guideline	5	001 – 002	This sounds a little like the staff member is discussing the staff member's thoughts – this should be a joint decision and the mother should have fully informed choice on timing of transfer home taking into account her needs, preferences and the support available to her as well as the evidence base about longer versus shorter hospital stays.	Thank you for your comment. We have revised the wording of this recommendation to emphasise the importance of taking into account the woman's preferences in addition to the clinical and other considerations. We have also added a recommendation about providing information about what to expect during the postnatal period, what support is available and who to contact if there are concerns before transfer to community care

					or before the departure of the midwife after home birth.
Lactation Consultants of Great Britain	Guideline	5	9	Vital to place a time frame on the first postnatal visit, and also that it is by a midwife and in person, as we have learned during the current pandemic.	Thank you for your comment.
Lactation Consultants of Great Britain	Guideline	6	3	Great to space out the visits but the ideal would be co ordination and collaboration between midwifery and health visiting teams to ensure that there is not a long gap between visits in this crucial early period – 14 days may be too long depending on circumstances.	Thank you for your comment. We have added a recommendation about the midwifery services ensuring that the transfer of care for midwifery to health visitors is clearly communicated between health care professionals and to the woman or parents so that care provision is continuous and without gaps. The recommendation about the first health visitor visit is a 'consider' recommendation so flexibility in different circumstances is expected.
Lactation Consultants of Great Britain	Guideline	6	007 - 019	Could infant feeding be included in the list of handover points?	Thank you for your comment. We have added this to the recommendation.
Lactation Consultants of Great Britain	Guideline	6	19	Could this final bullet point specifically include information sharing around feeding including any issues that have arisen; eg “concerns that the woman has about her own or her baby’s care, including around infant feeding”.	Thank you for your comment. We have added this to the recommendation.
Lactation Consultants of Great Britain	Guideline	7	3	This is an opportunity to highlight gap in support and signpost to for example local or accessible peer support or further specialised breastfeeding support services available	Thank you for your comment. Information about available support services are covered in different parts of the guideline, for example, information about available peer support in relation to breastfeeding is covered in the feeding section. Based on stakeholder comments we have also added a recommendation about providing

					information about available support, both statutory and voluntary, to women after they have given birth and before transfer of care from the maternity unit to community care (or before the midwife leaves after home birth) so that they know what support is available to them.
Lactation Consultants of Great Britain	Guideline	7	004 - 019	Could this include 'woman-centred'?	Thank you for your comment. We do not disagree with the sentiment and we think that the guideline is woman-centred. However, we have chosen not use this word in this recommendation, instead we are recommending how to communicate with the woman in a way that is woman-centred.
Lactation Consultants of Great Britain	Guideline	9	12	Breast comfort and inflammation is not the dame as 'signs of mastitis' which should be included as a separate bullet point	Thank you for your comment. Assessing breast discomfort and signs of inflammation should cover mastitis, but we have added symptoms and signs of mastitis to the list of potentially serious conditions that women should be aware of and seek medical advice if they occur.
Lactation Consultants of Great Britain	Guideline	14	28	The NICE link is included but could the BAPM link also be included here?	Thank you for your comment. The British Association of Perinatal Medicine guidance has not been accredited by NICE so we have not made a reference to it.
Lactation Consultants of Great Britain	Guideline	15	10	Vital to ensure that we value the importance of truly embedding BFI standards – as a minimum - across maternity and neonatal settings, as included in the NHS England plan and already happening in Scotland and Wales. This could be stated here, and the standards could be linked to.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.

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Lactation Consultants of Great Britain	Guideline	16	1	Great to see mention of safe bed sharing, but please refer to 'safer' rather than 'safe' – as nothing is 'safe'. Also please include location of baby – ie in same room as parent or carer for at least the first 6 months..	Thank you for your comment. We have amended the wording to "safer" as suggested. We did not review evidence on safer sleeping practices in general (apart from bed sharing/co-sleeping) but are aware of established guidance and have added this to a recommendation about providing information to parents about caring for their baby. In the rationale and impact section we provide some examples of sources for this guidance.
Lactation Consultants of Great Britain	Guideline	16	10	Where has the recommendation of '2 units of alcohol' come from? People metabolise at different rates.	Thank you for your comment. The 2 units of alcohol is based on the evidence from two case-control studies from the UK (see evidence review N).
Lactation Consultants of Great Britain	Guideline	17	2	Pleased to see the section on emotional attachment.	Thank you.
Lactation Consultants of Great Britain	Guideline	17	15	Not keen on the phrasing of this section and the way 'feeding' is included here as there is an implication that feeding is always challenging and this is not the case.	Thank you for your comment. The committee agrees so we have amended this to say "feeding concerns".
Lactation Consultants of Great Britain	Guideline	19	21	Could maternal mental health be added as its own bullet point for additional support?	Thank you for your comment. We have revised this to say complex psychosocial needs to include mental health problems.
Lactation Consultants of Great Britain	Guideline	19	22	As a diagnosis of / treatment for GORD (Gastro oesophogeal reflux disease) is relatively common – although usually this is in fact GOR not GORD and per NG1 should not be the case, we would caution against using GORD as a red flag for serious illness. Perhaps another suggestion would be pyloric stenosis?	Thank you for your comment. Actually, GORD is not listed as a red flag in this recommendation but the NICE guideline on GORD is referenced to contain more information because it lists red flag symptoms which suggest disorders other than GOR. This guideline, among other NICE guidelines, was used as a source for the list of red flags and is thus referenced as a source for more information.

Lactation Consultants of Great Britain	Guideline	20	004 - 009	Happy to see communication being spelled out like this.	Thank you.
Lactation Consultants of Great Britain	Guideline	20	10	Antenatal conversations about infant feeding are vital, however are notoriously easy to mis-manage and so leaning on the established evidence base provided by BFI seems sensible here.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
Lactation Consultants of Great Britain	Guideline	20	15	Not sure nutritional aspects of breastfeeding are the main focus of parents' decision making; perhaps better to concentrate on non nutritive aspects when trying to pique interest in breastfeeding in a family who have never considered it.	Thank you for your comment. The order of the bullets do not imply order of importance and the individual healthcare professionals can choose for themselves how exactly to discuss these issues with parents.
Lactation Consultants of Great Britain	Guideline	21	2	Good to point out the value of breastfeeding *'even if only done for a short while',* as long as this is not a statement for all families, but is tailored to specific circumstances and as part of facilitating fully informed choice.	Thank you for your comment. The committee agrees. Individualising the communication to fit the needs, preferences and circumstances of the women is recommended in the 'Principles of care' section and underpins all the discussions with the woman.
Lactation Consultants of Great Britain	Guideline	21	3	We are pleased to see the use of breastfeeding as comfort and to soothe baby	Thank you.
Lactation Consultants of Great Britain	Guideline	21	006 - 007	Great to see partners included here; we know how valuable they are to the mother infant dyad and it's important to note how they can be involved in the development of a strong responsive attachment for baby with both parents.	Thank you.
Lactation Consultants of Great Britain	Guideline	21	012 - 018	Lactation Consultants of Great Britain do agree that health professionals caring for women and babies should know about the	Thank you for your comment. Training and issues around competencies of healthcare professionals are not in the remit of this

				items detailed here, and we would welcome clarity on how this will be achieved.	guideline but we have stated some basic knowledge that healthcare professionals caring for women and babies in the postnatal period should have.
Lactation Consultants of Great Britain	Guideline	22	1	Evidence shows the importance of initiating early feeding 'when mum and baby are ready' – but pushing for this to happen too soon risks pushing the infant out of the normal biological pattern they follow in the hour or so after birth. Better to concentrate on signs of readiness to feed.	Thank you for your comment. We have changed the recommendation to reflect this.
Lactation Consultants of Great Britain	Guideline	22	003 - 011	Vital to ensure that we value the importance of truly embedding BFI standards – as a minimum - across maternity and neonatal settings, as included in the NHS England plan and already happening in Scotland and Wales. This could be stated here, and the standards could be linked to.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
Lactation Consultants of Great Britain	Guideline	23	1	Important to include information about the opportunities for infant feeding peer support	Thank you.
Lactation Consultants of Great Britain	Guideline	23	002 - 004	Face to face support is integral to good standard postnatal contacts, having a positive effect on families' experience of the postnatal care; however some aspects of enhanced care have been shown to effectively provided by videocall and other remote support during this current pandemic, and should be explored as opportunities going forward.	Thank you for your comment. The committee agrees face to face support is integral and this was also shown in the evidence. The committee therefore recommends that face to face breastfeeding support is offered, however, it could be supplemented by other forms such as remote contacts via digital platforms or telephone as needed/appropriate. The covid-19 pandemic has certainly emphasised the use of remote contacts, however, the guideline committee agreed that at the moment there is not

					enough evidence showing that remote support alone would be sufficient.
Lactation Consultants of Great Britain	Guideline	23	005 - 008	Pleased to note young mothers and those who have been disadvantaged in other ways mentioned specifically here	Thank you.
Lactation Consultants of Great Britain	Guideline	23	17	Link to breastfeeding assessment tool here?	Thank you for your comment. We assume you mean the UNICEF BFI breastfeeding assessment tool. The UNICEF BFI breastfeeding assessment tool is not a validated tool so we have not reviewed it and critically appraised it. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, we have made a reference to it in the rationale and impact section.
Lactation Consultants of Great Britain	Guideline	23	26	Fatigue is an aspect of parenting a new baby, rather than an aspect of breastfeeding per se – should it be in a general section, perhaps under safe sleep?	Thank you for your comment. The committee agrees that this was potentially misleading. What was meant that fatigue itself is not exclusive to breastfeeding but it may sometimes be more difficult to manage when breastfeeding because breastfeeding is always done by the woman, therefore we have revised the wording to say "strategies to manage fatigue when breastfeeding". Fatigue is also mentioned in the general section about topics to discuss specific that relate to the wellbeing of the woman and issues that may be challenging the postnatal period which might have an impact on bonding with the baby.
Lactation Consultants of Great Britain	Guideline	23	27	This sounds like a choice – This is not something which should be discussed in this way as you are referencing NICE FG guideline which states that artificial feeding is	Thank you for your comment. We have revised this point to "supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated".

				not ideal and other methods should be tried first.	
Lactation Consultants of Great Britain	Guideline	23	27	Combination feeding. – as an informed choice by mother – is a different thing.	Thank you for your comment. We have revised this point to "supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated".
Lactation Consultants of Great Britain	Guideline	24	004 - 015	Again, link to assessment tool for staff to use?	Thank you for your comment. The UNICEF BFI tool is not a validated tool so we have not reviewed it and therefore we are not directly referencing it in the recommendations. However, we make a reference to it in the rationale and impact section which can be clicked open directly underneath the recommendations in the published web version of the guideline.
Lactation Consultants of Great Britain	Guideline	24	016 - 019	Can we include a reminder that this should be demonstrated ‘hands off’ ie without touching the mother, giving full control to the mother, and signposting to more expert and experienced lactation support where appropriate.	Thank you for your comment, which the committee discussed. They concluded that in fact some people do want to have physical help with feeding and that if this is the case it should be permissible with their clear consent.
Lactation Consultants of Great Britain	Guideline	25	002 - 003	Antenatally this should only be an individualised and tailored discussion for those who have already made a fully informed choice or who have no choice but to formula feed.	Thank you for your comment. The committee agreed that those women who need to formula feed or those who are considering formula feeding should be given information about formula feeding already before birth so that informed decision can be made and so that if done, it can be done safely and appropriately. The discussions should of course continue in the postnatal period and perhaps more detailed information is more appropriate only when the feeding has started.

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Lactation Consultants of Great Britain	Guideline	25	017 - 022	It might be useful to include information about how 'remote' formula feeding support could look – we have seen some excellent practice emerge this year	Thank you for your comment. Although the committee acknowledge your point about the recent growing importance of providing support via video conferencing - or other remote means - they do not feel they have evidence to show it is working as well as in person, face to face support. The committee therefore did not feel there was a strong basis for any change to this recommendation.
Lactation Consultants of Great Britain	Guideline	26	008 - 009	'ensure they have the right information to help them make an informed decision'	Thank you for your comment. We have not made this change as we do not think it's necessary. The person supporting to make an informed decision is also the person providing the information.
Lactation Consultants of Great Britain	Guideline	35	011 - 012	There is a mention of the evidence and experience that information given to and received by families in the postnatal period is inconsistent. We would absolutely agree and we hope that this guideline will help to tighten it up – but we are not sure we can see details of how this will be achieved, in the guideline.	Thank you for your comment. The guideline is not attempting to be a detailed text book style source for healthcare professionals, however, it should encourage local arrangements for consistent information provision. Continuity of carer is also recommended particularly in relation to breastfeeding support and this should also enhance consistency of information provision.
Lactation Consultants of Great Britain	Guideline	General	General	Lactation Consultants of Great Britain would like to thank the guideline committee for the opportunity to comment on this document, and express our appreciation for the work that has been done by the committee.	Thank you.
Lactation Consultants of Great Britain	Guideline	General	General	If the PNC Guidance is covering the period up to 8 weeks after birth, should the GP postnatal check be included in it?	Thank you for your comment. Yes, the postnatal check by a GP at 6 to 8 weeks is included in the recommendations.

Midwifeexpert.com	Guideline	10	General	First visit -I am glad to see that the guidance suggests that midwives maintain the first home contact is within 12 hours. During COVID many trust have only undertaken this virtual- this needs to be revisited so women have face to face contact. Most UK women are being tested pre delivery, consideration needs to be undertaken for testing of any mother who has a home birth and of course community midwives visiting multiple homes.	Thank you for your comment. We have now made it explicit in the recommendation that the first visit should be face to face.
Midwifeexpert.com	Guideline	12	General	Information transfer is vital but computer / digital transfer must not be the only format. There seems to be little mention of debriefing mothers (links with perinatal mental health issues). Social and charity connections and local groups should be included.	Thank you for your comment. We are not entirely sure which recommendation this comment refers to, probably to the recommendation about communication between healthcare professionals at transfer of care. However, we have not made a recommendation about the format of information transfer but rather the content of it. ****We have added a recommendation about providing information about support available, including voluntary services.
Midwifeexpert.com	Guideline	13	General	Content of visits – important that mothers have time to debrief about birth experience but there appears to be no mention of support groups and charities APEC and AIMS GBS	Thank you for your comment. We have not specified the support services but have amended the recommendation to state that information about relevant support and birth reflection services should be provided if appropriate.
Midwifeexpert.com	Guideline	21	General	Length of stay I am concerned that this recommendation may imply that whilst domestic violence and safeguarding are mentioned there is little mention of other professional and social support at home.I do support the issue of individualised tailored care for each mother.	Thank you for your comment. We have added a recommendation about providing information before transfer of care from the maternity unit to community care or before the midwife leaves after homebirth about available support, both statutory and voluntary and who to contract if concerns arise.

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Midwifeexpert.com	Guideline	8	General	I agree with maintaining of 8 week post natal review and examination.	Thank you.
MUTU System (MUTU Holdings Limited)	Evidence review F	12	010 - 011	Evidence indicates importance of prevention of on-going and long term problems re: pelvic health following birth. Suggest add ''pelvic floor and gentle core exercise'' inserted as follows: ''Give women advice on lifestyle issues (such as diet, sleep, hygiene, pelvic floor and gentle core exercise) in the postnatal period''	Thank you for your comment. The text to which you refer is actually some of the data extracted from the included guidelines within that evidence review. These were discussed by the committee and considered as a basis for making recommendations. The committee did not use these statements verbatim in the guideline and instead agreed to make more general recommendations to ask the woman about her general health, assessing her wellbeing and discussing general topics that may affect her daily life, providing reassurance and further care as appropriate. The topics then listed are given as examples and are not intended to be exhaustive and so we cannot make the change you suggest.
National Child Mortality Database	Evidence Review M	015 - 017	16	Good to see a rounded discussion of the evidence surrounding bed-sharing and its impact on several aspects of infant care practice. It is always difficult to conduct Random Controlled Trials (RCTs) in this area as the maternal drivers for different infant care practices are so strong, they often override any allocation given by researchers and blinding is rarely an option, thus the highest standard of evidence is limited to observational studies with its usual attendant bias. The discussion seems appropriate and reflects what I have read myself in this literature.	Thank you for your comment.

National Child Mortality Database	Evidence Review N	018 - 020	23	Although women with severe mental illness have been flagged as a potential vulnerable sub-group, we have not come across many mothers with this condition in our Sudden Unexpected Death in Infancy (SUDI) observational studies of 400 deaths. We did not include data on parental drug use in our analysis of two case-control studies included in this review as we only collected this sensitive data in one of the studies. However, we did find evidence of an association between recreational use of illegal drugs and bed-sharing in our single study. Again, the discussion appears to be well-reasoned and comprehensive.	Thank you for your support.
National Child Mortality Database	Guideline	16	1	Completely agree with the recommendations as they are based on the latest evidence	Thank you.
National Child Mortality Database	Guideline	16	12	Child Death Overview Panel (CDOP) case reviews have shown that this can also be an issue when the parent has had a change in their dosage of medication. Suggest considering mentioning this as an example of when parents would be more drowsy than usual.	Thank you for your comment. This did not come up in our evidence review so we have not added this to the recommendation.
National Infant Feeding Network	Guideline	20	013 - 015	The recent NHS England joint support offer with Baby Friendly was has recently agreed, for all maternity services to achieve full accreditation by March 2024. This should be clearly recognised within the guidelines, indicating the importance of ensuring every mother and infant receive Baby Friendly care, and the benefit of this for both mother, infant and the unit. This would also ensure consistency around infant feeding practices	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.

				would be for maternity services to fully adopt the Baby Friendly standards in practice, and that this should be clearly recognised within the guideline. This acknowledgement is wider than just the benefits of breastfeeding.	
National Infant Feeding Network	Guideline	22	012 - 023	Supporting mothers to breastfeed: we felt conversations around feeding, particularly in the antenatal period are more complex than the guidance suggests and that there could be a reference to the Baby Friendly guidance and materials to support health professionals	Thank you for your comment. The committee agrees that the conversations around feeding can be complex. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
National Infant Feeding Network	Guideline	023 - 025	General	It would be helpful to provide links for Baby Friendly breastfeeding and formula feeding assessment tools	Thank you for your comment. The UNICEF BFI guidelines have not been accredited by NICE so we have not made a reference to them in the recommendations. However, we think that our recommendations do not contradict their guidance and overall they align well and we refer to it in the rationale and impact section which explain the recommendation.
National Infant Feeding Network	Guideline	24	001 - 003	Health professionals need adequate knowledge and skills to support women and we suggest an evidence based training programme to implement the Baby Friendly standards	Thank you for your comment. Training of healthcare professionals are not in the remit of this guideline.
National Perinatal Epidemiology Unit	Guideline	7	001 - 022	We have recently completed a (pre-pandemic) qualitative longitudinal study of 40 first time mothers' expectations and experiences of postnatal care in England. This illustrated that mothers' postnatal	Thank you for your comment and sharing your findings. The study was not considered for inclusion in our evidence reviews because it was not published within the time limit of our literature searches. The committee considered the suggestions and

				experiences (and ultimately wellbeing) were profoundly affected by the extent to which health professionals interacted with them in ways that built up their parenting confidence or undermined it. Many pregnant women feared that they would be judged by health professionals on their parenting (not just breastfeeding), and postnatally many indeed had encounters with professionals who gave them information and negative feedback in ways that left them feeling criticised or told off. We therefore suggest that line 12 could be expanded to give more explicit guidance: "supportive, respectful, non-judgmental, and aimed at building up parents' confidence though a strengths-based approach". This study also found that mothers had substantial unmet needs for information about postnatal care itself – its purpose, timing, location, and the different professionals who would be involved. They contrasted this with the clear information that is given to pregnant women about the antenatal care pathway, and some had experienced avoidable stress because they lacked this information. Mothers also highlighted the importance of specific information when they arrived on the postnatal ward about the ward itself, its	agreed that the tone and content of the recommendations should already capture these issues by highlighting the need for compassionate, respectful and person-centred communication and therefore decided not to include the suggested additions to the recommendations.

				routines and rules, and the support they would be offered. We therefore suggest that lines 1-22 could be strengthened by an additional recommendation that mothers be given information about the full local postnatal care pathway, ideally available in pregnancy and available at any time postnatally, and about what to expect on the postnatal ward. References: McLeish J, Harvey M, Redshaw M, Alderdice F. A qualitative study of first time mothers' experiences of postnatal social support from health professionals in England. Women and Birth, 2020. https://doi.org/10.1016/j.wombi.2020.10.012 McLeish J, Harvey M, Redshaw M, Alderdice F. "Reassurance that you're doing okay, or guidance if you're not": A qualitative descriptive study of pregnant first time mothers' expectations and information needs about postnatal care in England. Midwifery. 2020 Oct;89:102813. doi:10.1016/j.midw.2020.102813	
National Perinatal Epidemiology Unit	Guideline	29	General	The mothers in the study mentioned above asked for information about postnatal life to be scenario-base and timely, addressing typical problems and answering the question 'Is this normal?' We suggest that there could be a research recommendation about the most effective ways to make written	Thank you for your comment. There were many areas in the guideline that further research was considered and the guideline committee needed to prioritise, unfortunately a research recommendation on written postnatal information for women wasn't prioritised.

				postnatal information accessible, relevant and navigable.	
Neonatal Critical Care CRG (NHSE)	Guideline	14	1	We suggest that the initial examination within 72 hours should include either a pre- and post-ductal oxygen saturation measurement in all babies or targeted for those with concerns regarding colour, perfusion or signs of cardiovascular or respiratory disease.	Thank you for your comment. The list in the recommendation are routine examinations carried out for all infants and does not tell exactly how the assessments for the different issues should be done. Oxygen saturation measurement was not considered something that should routinely be done for all babies.
Neonatal Critical Care CRG (NHSE)	Guideline	14	19	We suggest that jaundice is specifically mentioned here as well as being referred to later (line 35) as the bullet points are likely to be used as a check list and it is important to highlight jaundice as part of the examination.	Thank you for your comment. Jaundice is covered by checking colour of skin and sclera (added as this can be a more relevant way to check for jaundice for babies with darker skin tone).
Neonatal Critical Care CRG (NHSE)	Guideline	14	19	We are concerned that this section appears to be focussed soley on assessing symptoms and signs of illness in babies after discharge home and suggest that there is reference to assessment of babies before their discharge from hospital. This should include assessment of babies with concerns or risk factors requiring regular observations and the use of NEWS (Newborn Early Warning Score) or NEWTT (Newborn Early Track and Trigger) type assessment tools.	Thank you for your comment. This guideline only covers routine care and specialist care for babies with e.g. risk factors or those needing regular observations are outside the remit of this guideline.
Newcastle Parent Infant Partnership NEWPIP, c/o Children North East	Guideline	17	001 - 004	The recommendations under Promoting Emotional Attachment completely disregard the baby as a person with a mind or emotions or the fact that attachment is a quality of relationship. Also, only focussing on Attachment per se, disregards the more urgent imperatives of the mother-infant relationship generally. The interventions	Thank you for your comment. We think that having its own section in the guideline dedicated to promoting the relationship between the baby and the parents highlights the importance of the baby as a person with a mind and emotions. We have revised the definition of emotional attachment in the Terms used in this guideline section. The outcome of mother's subjective perceptions

				which are recommended only concern assessments of the "mother's subjective perceptions of the quality of their relationship to the baby when the baby is 12-18 months". Overall, and including the studies which are listed as excluded for varying reasons, the committee seem to have studiously disregarded the entire range of academic and clinical work carried out in the UK over the past 40 years which has roots in the psychoanalytic field. I found no reference to such important sources as the Tavistock & Portman Clinic or Anna Freud Centre or AIMH UK or WAIMH or the WAVE Trust or the 1001 Critical Days movement or the Parent-Infant Foundation UK. There is no reference to the distinguished and highly regarded scholarship contained in significant recent UK published works for example: "Transforming Infant Wellbeing - Research Policy and Practice for the first 1001 Critical Days" edited by Penelope Leach, which is so widely recognised as a collection of compelling, authoritative and crucial studies on matters pertaining to postnatal care, from a wide range of experts and institutions. This is just one example of a wealth of clinical and academic studies in the growing field of Infant Mental Health which seems to have been entirely	of the quality of their relationship was only one of the outcomes of interest in the evidence review and the outcomes of interest also included outcomes from the perspective of the baby including proportion of babies displaying an insecure attachment type (which includes ambivalent, avoidance, disorganised) when the baby is 12 to 18 months of age and social behaviour of the baby when the baby is 12 to 18 months of age. The evidence review O, appendix A, includes the details about the review protocol, which outlines the scope of this particular review, including which types of publication were considered for inclusion. Appendix B details the search strategies used. Considering the depth postnatal care as a topic, the scope of the guideline needed to be very selective of the reviews to be conducted. So while we recognise the importance of this issue, a focused review question on interventions to promote emotional attachment was prioritised. NICE would very much welcome any case studies or examples of best practice and we would encourage you to submit these to NICE if relevant: https://www.nice.org.uk/about/what-we-do/into-practice/shared-learning-case-studies The principles and processes of recruitment of guideline committee members is outlined in the Developing NICE guidelines: the manual, chapter 3 (https://www.nice.org.uk/process/pmg20/chapter/decision-making-committees) and all committee members are recruited in

				disregarded. Our service, NEWPIP has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact Peter.Toolan@children-ne.org.uk I would also like to register a concern that, despite the documentation appearing to provide comprehensive information on the process NICE carried out, it lacks any transparency regarding how members of the committee were selected or on what basis.	accordance with NICE's policy and procedure for recruitment and selection to advisory bodies and topic expert groups (https://www.nice.org.uk/about/who-we-are/policies-and-procedures) An open recruitment was carried out via the NICE website during the scoping process of the guideline looking for a multidisciplinary group of professionals and lay members with interest and expertise in specific areas related to postnatal care. The specific roles recruited to the committee were informed by the stakeholders during the scoping process.
NHS Grampian	Guideline	16	13	I believe that “taken” should be replaced with “used” as not all drugs are taken e.g. cannabis	Thank you for this comment, we have made the suggested change.
NHS Grampian	Guideline	21	13	I have concerns that not all healthcare professionals have this knowledge and understanding. Potentially add bullet point about signposting to appropriate HCP e.g. lactation consultant, infant feeding midwife.	Thank you for your comment. We are hoping that this recommendation will change the expectations of basic knowledge about breastfeeding that healthcare professionals providing postnatal care should have. Of course, in a case by case basis it may be appropriate to signpost to another professional if one feels that they do not have the relevant knowledge but we have not included this in the recommendations. Elsewhere in the guideline, where breastfeeding assessment is discussed, the guideline now says that referring to additional support such as a lactation consultation should be considered if there are ongoing concerns.

Postnatal Care

Consultation on draft guideline - Stakeholder comments table
16/10/2020 – 25/11/2020

NHS Grampian	Guideline	26	9	Insert phrase “and evidence based” after the word informed. It is well documented that personal experience and not evidence base can lead to inappropriate and ill informed decision making.	Thank you for your comment. The committee agrees, but this has already been covered under the section 'Principles of care' we state that information provision should be evidence based.
North West London Local Maternity System (NWL LMS)	Comment Form Question 3	N/A	N/A	*Q. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) A. North West London Local Maternity System are of the opinion that it would be helpful for the user if the guidelines explicitly laid out the expectations of clinical examination on both the first visit after discharge following the birth and on day 5 for all women to be offered a full set of observations and postnatal examination, including temperature, respiration, pulse, blood pressure, breasts, abdominal palpation, wound check (perineum and/or caesarean), lochia, bladder and bowel function and legs.*	Thank you for your comment. The recommendations outline various aspects of the woman's health that should be assessed at each postnatal contact by a midwife, including signs or symptoms of infection, pre-eclampsia, pain, breast and nipple comfort, bladder and bowel function, perineal health, but we do not specify the exact examinations that should be conducted to assess these health issues because this was not included in the scope of the guideline and so they were not reviewed by the guideline committee, and the guideline is not attempting to provide the detail of a text book.
North West London Local Maternity System (NWL LMS)	Guideline	6	12	*North West London Local Maternity System request that the NICE committee tasked with revising the NICE Postnatal guidance considers the need to insert a recommendation that full discharge information be given to community midwives, particularly regarding any abnormal blood pressure readings in their pregnancy, labour/birth and immediate postnatal period. Evidence to support our recommendation comes from HSIB Safety recommendation (2020) referring to a specific case where community staff were unaware that the Mother’s BP had been raised during labour*	Thank you for your comment. We realise the importance of good communication between healthcare professionals at transfer of care, therefore, we have made a recommendation about this and it should cover the issue you have raised. This recommendation includes that information about the pregnancy, birth, postnatal period and any complications; and the plan of ongoing care, including long-term management is shared between healthcare professionals (the latter added based on consultation comments).

				as this had not been included on the discharge summary.	
North West London Local Maternity System (NWL LMS)	Guideline	9	15	*North West London Local Maternity System (NWL LMS) request that the NICE committee tasked with revising the NICE Postnatal guidance considers the need to insert a recommendation that all women have their blood pressure checked on both the first visit after discharge following the birth and on day 5. The Local Maternity System believe clear and instructive guidance in relation to blood pressure reading at postnatal community visits/appointments could contribute to a reduction of morbidity and mortality. Evidence to support our recommendation comes from: Burnham et al (2013) discussed that maternal BP usually falls immediately after delivery, then tends to rise, reaching a peak three to six days post-partum in both mothers with a normal BP in pregnancy and those with raised BP during pregnancy.*	Thank you for your comment. We have not provided this level of detail in the recommendations about how to assess the different health issues or exactly which measurements to take but we think the assessment of signs and symptoms of pre-eclampsia already covers this point.
Obstetric Anaesthetists' Association	Guideline	General	General	There is a reasonable amount included on pain (mostly perineal) but nothing about pain relief. Given that so many women leave hospital within 24 h of childbirth should advice about pain relief (not just perineal) be included?	Thank you for your comment. Pain relief was not in the scope of the guideline and therefore has not been covered. However, we have made a specific note about safe medicine use when breastfeeding.
Oxford Parent-Infant Project (OXPIP)	Guideline	General	General	My view is that the support identified for parents postpartum for emotional wellbeing of the infant is totally inadequate. There are many families for whom just giving a bit of information and advice about how to bond with their baby will not survice. Many	Thank you for your comment. We are glad to have had the opportunity to do an evidence review on the topic of interventions to promote emotional attachment and consequently to have a whole section on promoting emotional attachment in the

				families need more psychotherapeutic in depth work in order to improve the quality of relationship provided for their infant. Many parents will have come from emotionally deprived backgrounds and without this being addressed will not be able to provide a better experience for their own children. There is a rich and solid evidence base for parent infant therapy and other related forms of support that need to be included in the range of interventions on offer to parents. The mental health and emotional wellbeing of parents needs to be considered when responding to the needs of the infant. It should be a whole family approach.	guideline. Unfortunately evidence on interventions in this area is limited. The committee agrees that some families will need more support in bonding with their babies and the committee thus gave some examples of the parents that might need additional support. This guideline covers routine postnatal care and specialist care is outside the scope of this guideline, for example interventions for parents who struggle with bonding with their baby is not covered in this guideline. Postnatal mental health otherwise is covered by the NICE guideline antenatal and postnatal mental health.
Oxford Parent-Infant Project (OXPIP)	Guideline	General	General	As a clinical psychologist with a background in CAMHS and specialist expertise in parent-infant psychotherapy, I cannot emphasise enough the paramount importance of providing parents and infants a therapeutic service from conception to two years (i.e. the first 1001 critical days). Unlimited scenarios can put the relationship between parent and infant under great strain, including ante and postpartum depression, anxiety disorders including OCD and PTSD, unresolved childhood issues of loss and trauma, recent trauma such as a difficult birth or previous experience of miscarriage or still birth. Without the right professional help, the parent-infant relationship is not only under extreme psychological pressure, it is in grave peril. Babies cannot wait: with one million connections forming in their brains every minute in the first 18 months of life, this is a	Thank you for your comment. This guideline covers the routine postnatal care and specialist care is outside the scope of this guideline. For example we reviewed evidence on the interventions that can promote emotional attachment among infant-mother dyads in general (i.e. with no specific pre-existing problems). But interventions specifically for parents who struggle with bonding with their baby is not covered in this guideline. Postnatal mental health otherwise is covered by the NICE guideline antenatal and postnatal mental health.

				critical window of opportunity in which to intervene therapeutically and bring about meaningful, lasting change: change that will improve the child's social and emotional development, readiness for school, academic success in adolescence, and the chances of success in adulthood (i.e. being responsible citizens, employed, drug and alcohol free, offering a stable family unit). I urge the NICE guidelines to include in their recommendations the need for specialist parent-infant psychotherapeutic services which support a loving and nurturing bond between parent(s) and infant. If we don't support our infants' emotional development today, we fail them as adults tomorrow.	
Oxford Parent-Infant Project (OXPIP)	Guideline	General	General	As a clinical psychologist with a background in CAMHS and specialist expertise in parent-infant psychotherapy, I cannot emphasise enough the paramount importance of providing parents and infants a therapeutic service from conception to two years (i.e. the first 1001 critical days). Unlimited scenarios can put the relationship between parent and infant under great strain, including ante and postpartum depression, anxiety disorders including OCD and PTSD, unresolved childhood issues of loss and trauma, recent trauma such as a difficult birth or previous experience of miscarriage or still birth. Without the right professional help, the parent-infant relationship is not only under extreme psychological pressure, it is in grave peril. Babies cannot wait: with one million connections forming in their brains every	Thank you for your comment. This guideline covers the routine postnatal care and specialist care is outside the scope of this guideline. For example we reviewed evidence on the interventions that can promote emotional attachment among infant-mother dyads in general (i.e. with no specific pre-existing problems). But interventions specifically for parents who struggle with bonding with their baby is not covered in this guideline. Postnatal mental health otherwise is covered by the NICE guideline antenatal and postnatal mental health.

				minute in the first 18 months of life, this is a critical window of opportunity in which to intervene therapeutically and bring about meaningful, lasting change: change that will improve the child's social and emotional development, readiness for school, academic success in adolescence, and the chances of success in adulthood (i.e. being responsible citizens, employed, drug and alcohol free, offering a stable family unit). I urge the NICE guidelines to include in their recommendations the need for specialist parent-infant psychotherapeutic services which support a loving and nurturing bond between parent(s) and infant. If we don't support our infants' emotional development today, we fail them as adults tomorrow.	
Oxford Parent-Infant Project (OXPIP)	Guideline	General	General	I have worked in the NHS for 40 years, as a nurse, and latterly an HV working with mothers with post-natal depression. and alongside for the last 26 years with Oxpip. There is tremendous work, happening with m/ws, drs, hvs, but they are under stress with reduced capacity. There needs to be more on emotional health support for the parents and baby from conception to 2years. We know that traumatic birth can cause learning delay in babies and the ability of parents to develop secure attachments. It is not about just talking about attachment it is having access to parent-infant therapy to deal with any issues, (ie CSA, 'ghost in their pasts' trauma, also including ante and postpartum depression, anxiety disorders including OCD and PTSD, unresolved	Thank you for your comment. The committee agrees with you about the importance of emotional health and good parent-infant relationship. While identification and management of postnatal mental health problems as such is not covered by this guideline but another NICE guideline (CG192 Antenatal and postnatal mental health), we have put emphasis on emotional and mental health in this guideline by recommending that the woman's psychological and emotional wellbeing is assessed at every postnatal contact. We have also recommended that symptoms and signs of potential postnatal mental health problems are discussed and information given about how to seek help. We are also glad that we were given the opportunity to

				childhood issues of loss and trauma, recent trauma such as a difficult birth or previous experience of miscarriage or still birth. Without the right professional help, the parent-infant relationship is not only under extreme psychological pressure, it is in grave peril.including ante and postpartum depression, anxiety disorders including OCD and PTSD, unresolved childhood issues of loss and trauma, recent trauma such as a difficult birth or previous experience of miscarriage or still birth. Without the right professional help, the parent-infant relationship is not only under extreme psychological pressure, it is in grave peril. Readiness for school, resilience are all helped by parent-infant psychotherapy as the improvement of parental anxiety and depression. There is also a huge need to provide specialist parent infant work for those mothers with a Personality Disorder diagnosis.	conduct a review on interventions to promote emotional attachment, although the evidence base for this was limited. We specifically mention that some parents, particularly those with adverse childhood experiences, those who have been in care, those with complex psychosocial needs, and those who have experienced traumatic birth might be in a need of additional support in relation to bonding with their babies. However, our review did not look at interventions for parents with existing problems with bonding. Specialist care in general is not in the remit of this guideline and we have therefore not commented on this. However, we have made it clear that if there are concerns about the woman's or baby's health, referral to specialist care should be made
Parent Infant Foundation	Evidence Review H	General	General	This review lacks discussions of tools that can be used to used to assess the quality of the parent-infant relationship. For example, the MORS is validated as a screening tool for use by health visitors. (Milford, R, Oates, J. Universal Screening and early intervention for maternal mental health and attachment difficulties. Community Pract. 2009;82(8):30.)	Thank you for your comment. Tools to assess the parent-infant relationship were not prioritised as interventions by the committee when the protocol for this review was developed, therefore evidence on these tools were not assessed and discussed in the review.
Parent Infant Foundation	Evidence Review O	General	General	There are many relevant studies missing from Evidence Review. We believe this is because the scope of the review focused on studies that measured the impact of postnatal interventions on interactions and	Thank you for your comment. We agree that if we had looked more broadly at measures of parent interaction at earlier time points a broader body of evidence would have been included. However, the definition of

				attachment style at 18 months. If the search terms had looked more broadly at measures of parent-infant interaction, relationship quality, attunement and other related concepts at different time points, the committee would have found a much broader body of evidence to draw on. There are a number of evidence based brief interventions known to strengthen early relationships. These include brief interventions that can be offered to parents by midwives and health visitors in their contacts with families. For example, there is emerging evidence that the NBO and NBAS are effective in improving parent-child interaction although there is a need for higher quality evidence. Barlow, J., Herath, N. I., Torrance, C. B., Bennett, C., & Wei, Y. (2018). The Neonatal Behavioral Assessment Scale (NBAS) and Newborn Behavioral Observations (NBO) system for supporting caregivers and improving outcomes in caregivers and their infants. Cochrane Database of Systematic Reviews, (3).	emotional attachment in the review was based on Bowlby's model of attachment theory and internal working models, where it is not possible to assess patterns of attachment in infants until late in the first year.
Parent Infant Foundation	Guideline	5	009 - 012	We welcome the recommendations that there should be a face to face visit 12-36 hours after families return home so that families feel well supported. The Evidence Review C (page 13 line 25) suggests that the committee decided not to make different recommendations for more vulnerable groups of women. However we believe that vulnerable women, including those where there are safeguarding concerns, should be seen earlier rather than later. 36 hours is a	Thank you for your comment. Based on stakeholder feedback, the committee revised the recommendation to say within 36 hours (instead of 12 to 36 hours). The recommendation gives a window within which the visit should happen and the committee agrees that individual considerations may be needed in regards to the exact timings.

				long time for these families to go without support.	
Parent Infant Foundation	Guideline	013 - 020	General	In addition to the section on promoting emotional attachment, there are opportunities in the guidance to encourage practitioners to observe babies' emotional wellbeing or any signs of early distress or relational trauma.	Thank you for your comment. We think that the general assessment of the wellbeing of the baby, woman and the family life as well as discussion around emotional attachment will give indication to any potential concerns around the baby's emotional wellbeing and appropriate referrals and follow-up would be arranged as with any other concern.
Parent Infant Foundation	Guideline	17	001 - 021	The section on promoting emotional attachment only includes a requirement to talk to parents about emotional bonding and attachment, to promote behaviours that support attachment, and to discuss any challenges. This section needs to go much further and set out the need for professionals to observe of interaction at all contacts and to assess the quality of parent-infant relationships as part of the comprehensive assessment of families. There are clinical tools that can support this, such as the MORS. The guideline should recommend that parents be referred for additional specialist parent-infant support if there are concerns about early relationships. In areas where there is a specialist parent-infant team (also known as an infant mental health service), midwives and health visitors can gain training and consultation support to help them to carry out these early assessments and make judgements about the wellbeing of early relationships in a family and what additional support may be required.	Thank you for your comment. During the scoping process interventions to promote emotional attachment was prioritised and assessment of parent-infant relationship was not covered by the scope of this guideline. We have acknowledged in the recommendations that some parents may need additional support and specialist parent-infant teams might well be the right professionals to provide that support in the areas where they are available.

Parent Infant Foundation	Guideline	17	21	Mental health problems, birth trauma and other experiences of trauma should be added to the list of factors that may mean some families require additional help with early relationships.	Thank you for your comment. The committee agrees that this may be the case and have added experience of a traumatic birth to the list, we have also made a revision to say complex psychosocial needs.
Parent Infant Foundation	Guideline	42	016 - 018	The guidance states that “There was limited evidence on how to promote attachment between the mother and baby, and it did not show any specific interventions to be effective, so the recommendations are based on the committee’s knowledge and experience.” In fact, we believe there is plenty of evidence in this space and encourage further work to understand this evidence base. There are many relevant studies missing from Evidence Review. We believe this is because the scope of the review focused on studies that measured the impact of postnatal interventions on interactions and attachment style at 18 months. If the search terms had looked more broadly at measures of parent-infant interaction, relationship quality, attunement and other related concepts at different time points, the committee would have found a much broader body of evidence to draw on.	Thank you for your comment. We agree that if we had looked more broadly at measures of parent interaction at earlier time points a broader body of evidence would have been included. However, the definition of emotional attachment in the review was based on Bowlby’s model of attachment theory and internal working models, where it is not possible to assess patterns of attachment in infants until late in the first year.
Parent Infant Foundation	Guideline	General	General	Ideally, services should think holistically about families in the provision of postnatal care. This involves considering the wellbeing of mothers, fathers/partners and babies, and the relationships between them. Overall we felt the document would benefit from recognising the importance of a “think family” approach, where fathers and partners’ wellbeing, needs and preferences are also	Thank you for your comment. The committee discussed these issues - which were also raised by a number of other stakeholders - and agreed to respond by editing certain recommendations so they now also refer to partners or to 'parents' rather than just mothers. These changes were made in particular to recommendations about the

				taken into account and they are involved in their babies' care. The guidance needs to recognise fathers and partners' critical role as supporters of the woman and caregivers to the baby, and the contribution they can make to improving outcomes for both. In addition, the current guidance offers no direct support to fathers/partners in their own right, but evidence shows that the transition to parenthood can also have an impact on their wellbeing, which can also have consequences for the rest of the family. We suggest that the guidance should encourage professionals to engage directly with fathers/partners, and to enquire about their wellbeing and any concerns they have about their baby. We do recognise that family forms vary. There is also a difference between a woman's healthcare, where her partner can be seen as a supporter, and the babies' care, where fathers and partners should be engaged as caregivers alongside women. This can make the wording of guidance difficult in places. It may be that there need to be some general principles about a family centred approach at the top of the guidance alongside some changes to specific wording. Examples where the guidance talks only about a woman, and should consider talking about parents include "her baby" (page 4, line 9) "concerns that the woman has about her own or her baby's care." (page 6, line 19). Section 1.2.1 (page 8) focusses entirely on the woman, but many of the topics listed would ideally be	care of the baby and decisions about such issues as feeding.

				discussed with both parents particularly lines 10-21. Discussions about emotional wellbeing and mental health should also involve both parents/partners where this is possible and appropriate.	
Parent Infant Foundation	Guideline	General	General	When a mother or her baby has to stay in hospital for longer after birth (particularly when babies are in NICU) then the delivery of postnatal care happen at different times and in different settings to the “usual” care pathway. However it is really important that these families get the full range of assessments and support offered to other families, as they are likely to have additional needs as a result of their experiences. At the moment, some families fall through gaps in the system – for example, if babies are in NICU, then there might not be a health visitor visit, which may mean that mum’s mental health is not assessed. It would be helpful for the guideline to be clear that it is important for all elements of the guideline – relating to both the woman and the baby – to be delivered to all families. In situations where the family are in hospital for longer, there may be changes to who delivers the care and when and where it takes place. There may need to be separate checks for the woman and for her baby. Discussion and planning between professionals is key to ensure no families fall through the gaps.Similar discussions are required if mothers and babies are separated for other reasons, for example if babies are removed into the care system at birth.	Thank you for your comment. Specialist care as such is outside the scope of this guideline so we have not commented on it. However, the recommendations should apply to all routine postnatal care and thus be applicable to care of the woman even when the baby might be receiving specialist care. We have also specifically stated that any complications, plans for ongoing care or any concerns about the woman's or baby's health or care should be communicated between the healthcare professionals to ensure continued and appropriate care provision. The guideline has separate sections for the care and assessment for the woman and for the baby and while in most cases these can be done at the same time. The committee agrees that in some cases this would require separate checks/visits because either the woman or the baby is not present. This should be ensured by the local arrangements.

Pregnancy Associated Osteoporosis Group (PAO) Patient Expert Group affiliated to the Royal Osteoporosis Society	Evidence Review A	22	009 - 011	We would like to raise the query if any of the committee have any experience or expertise of patients with pregnancy associated osteoporosis (PAO) - we are concerned this may not have been considered when drawing up these guidelines. For these patients it is vital they are retained in hospital and fully investigated and treated to prevent injury to themselves and their babies. Although there are no specific research studies, the condition itself is well documented in medical literature, although this primarily focuses on causes and treatment. However, one research paper 'Pregnancy-related osteoporosis & spinal fractures', Karen Yeong Young, Simon Eun Han et al, Obstetric & Gynecology science, 2017, Jan, 60(1), 133-137, ncbi_nlm.nih.gov, states "Although postpartum osteoporosis is relatively rare, we should recognise the potential risk factors & main symptoms of postpartum osteoporosis to prevent fractures & further sequelae". One PAO patient commented "if I had been retained in hospital and in particular my pain levels assessed & checked sooner postpartum, or even later via postnatal assessment, then earlier diagnosis could have been made. This could have prevented my vertebral fractures & the terrible pain & mental anguish I suffered & the impact on my family and in particular on my baby. My pain & concern was dismissed, I was not assessed & sent home within 24 hours of giving birth. It was insisted by midwives I had to care for my baby, but	Thank you for your comment. Specific recommendations for women with pregnancy associated osteoporosis were not made on length of postpartum stay as women receiving specialist care due to a high-risk pregnancy and women who become high risk due to intrapartum complications are not included in the scope of the guideline.

				when I tried to pick her up my spine collapsed (I now know it fractured) & I dropped my baby. Later after diagnosis, I was not allowed to lift or carry my baby to allow spinal fractures to heal. All this might not have happened or been necessary with better checks and assessments. This obviously all affected bonding with my baby. My health & physical appearance have been impacted, probably for life, due to poor initial care & checks & assessments postpartum & postnatally".	
Pregnancy Associated Osteoporosis Group (PAO) Patient Expert Group affiliated to the Royal Osteoporosis Society	Evidence Review A	23	029 - 033	We would support new research into length of postpartum stay, to ensure adequate checks & assessments are given, especially in relation to PAO which presents commonly from “birth up to eight to twelve weeks after delivery” www.theros.org.uk One PAO patient commented, “When I fractured after the birth it took months to get diagnosed”. Doing even basic checks, in terms of assessing how well a woman is coping could help to ensure women are not sent home unable to physically cope. Another PAO patient commented about her hospital stay; they knew I couldn’t get out of bed, lift my newborn, lift a cup of water”, but she was still sent home with no assessments. These are indicators of PAO and would help in getting diagnosis and the correct treatment and prevent further fractures. Subsequent fracture risk of women with Pregnancy & Lactation Associated Osteoporosis after median of 6 years follow up, I. Kyvernitakis et al, Osteoporosis International, 2018,	Thank you for your comment. Specific recommendations for women with pregnancy associated osteoporosis were not made on length of postpartum stan as women receiving specialist care due to a high-risk pregnancy and women who become high risk due to intrapartum complications are not included in the scope of the guideline.

				29,135-142, German research study says"Our results emphasize the severity of Pregnancy & Lactation Associated Osteoporosis and that prompt diagnosis is of utmost importance" ..... "This study shows that 82.6% of patients were still in medical care after a median follow up of six years.... Similarly 71% of patients with fractures reported restrictions in everyday life.... Patients with fractures were frequently in medical care, compared to patients without fractures." "Almost a quarter of patients will sustain a subsequent fracture." "This study shows there is a significant correlation between the number of fractures at the time of diagnosis and subsequent fracture risk." "Pregnancy & lactation associated osteoporosis occurs in the last trimester or immediately postpartum."	
Pregnancy Associated Osteoporosis Group (PAO) Patient Expert Group affiliated to the Royal Osteoporosis Society	Evidence Review E	008 009	032 - 042 001 - 003	We strongly support the fact that a routine postnatal assessment 6-8 weeks postpartum be carried out for all and note a second later assessment would also be beneficial in regard to PAO. This is particularly important in relation to PAO, where it has been documented that mothers can fracture after hospital discharge & their PAO may be affected by breastfeeding – “Pregnancy-associated osteoporosis: a UK case series & literature review", S.A. Hardcase, F.Yahya & A.K. Bhalla, Osteoporosis International, 30,939-948 (2019), link-springer.com & “Clinical Aspects of Pregnancy & Lactation Associated Osteoporosis” Adi Cohen, Colombia University Irving Centre,	Thank you for your comment. The remit of the guideline includes postnatal care up to 8 weeks after birth, therefore the committee were unable to write recommendations for later assessment as suggested.

				September 2020, presentation, ASBMR 2020. See also www.theros.org.uk information page on PAO which states “bones break easily, around the time a woman is giving birth, causing pain and disability..... Commonly bones seem to break when a woman gives birth or up to eight to twelve weeks after delivery" Subsequent fracture risk of women with Pregnancy & Lactation Associated Osteoporosis after median of 6 years follow up, I. Kyvernitakis et al, Osteoporosis International, 2018, 29,135-142, German research study says"Our results emphasize the severity of Pregnancy & Lactation Associated Osteoporosis and that prompt diagnosis is of utmost importance" ..... "This study shows that 82.6% of patients were still in medical care after a median follow up of six years.... Similarly 71% of patients with fractures reported restrictions in everyday life.... Patients with fractures were frequently in medical care, compared to patients without fractures." "Almost a quarter of patients will sustain a subsequent fracture." "This study shows there is a significant correlation between the number of fractures at the time of diagnosis and subsequent fracture risk." "Pregnancy & lactation associated osteoporosis occurs in the last trimester or immediately postpartum." https://www.nature.com/articles/s41598-019-43049-1 Changes in metabolic bone profile associated with pregnancy or lactation,T.	

				Miyumoto et Al, Scientific Reports 9, Article Number 6787 (2019), Nature.com This research study reports "all patients experienced severe back pain within 3 months postpartum and had 1-8 (average 3.7) vertebral fragility fractures" We also strongly recommend measuring of height for any ladies complaining of back pain during the postnatal assessment, as this is an indicator of a possible PAO. In fact, one PAO patient commented “this was the only reason I was taken seriously.”	
Pregnancy Associated Osteoporosis Group (PAO) Patient Expert Group affiliated to the Royal Osteoporosis Society	Evidence Review H	008 009	036 - 040 001 - 030	We strongly support pain assessment and further research into pain levels and the creation of a validated pain score as a new assessment tool. We feel this would particularly help with early diagnosis of PAO, as the majority of PAO ladies present with acute back or hip pain including muscle spasms in some cases, but is too easily dismissed as “muscular” or “normal for postnatal women to have back pain”. A random group of PAO ladies (!0) were asked their level of pain on a scale of pain 1-10 after fracturing. (10 being the highest). One PAO patient commented ”My pain was a 10plus due to spasms”. Identifying physical issues early on may avoid additional problems of PAO ladies receiving incorrect treatment due to physiotherapy, or from other professionals who could unknowingly, do more damage to the skeleton. One PAO patient commented, “After seeing my GP for back pain which was dismissed as normal, I visited an osteopath and that night I was	Thank you for your comment. Specific recommendations for women with pregnancy associated osteoporosis were not made in relation to tools for clinical review of women as specialist care for women with pre-existing conditions are excluded from the scope of the guideline.

				unable to get out of bed. I eventually discovered I had sustained 4 fractures." Pain assessment is crucial for PAO and would help to prevent women being undiagnosed and left as one PAO patient commented, "in extreme pain and doctors and nurses responding to you as if you're a drama queen". Also, ladies requiring increased analgesia for back, hip or ribs should be a red flag for PAO.	
Pregnancy Associated Osteoporosis Group (PAO) Patient Expert Group affiliated to the Royal Osteoporosis Society	Evidence Review O	013 014	003 - 004 004	We welcome the comment that women with physical disability may need further consideration, but are concerned because PAO is normally unknown – it normally first needs to be diagnosed and early diagnosis is vitally important to prevent damage of the skeleton or further harm to mothers and babies emotional bond. We welcome your comment that "the most important thing promoting emotional attachment is the wellbeing of the caregiver" and would like to highlight this comment, given the impact of PAO on mothers, who quite often need the assistance of family, friends or professional help to care for their babies. "I couldn't take care of my baby myself for months, I had to quit breastfeeding". Emotional attachment is a crucial issue for PAO ladies as one PAO patient commented, "the loss of time with my newborn was the toughest psychological pain".	Thank you for your comment. Diagnosis of PAO is outside the scope of this guideline.
Pregnancy Associated Osteoporosis Group (PAO) Patient Expert Group affiliated to the	Guideline	9	007 - 028	We support the fact that pain will be checked at each midwife visit and postnatal checks, but spine, hip and rib pain should be added to the list of pain areas to be checked for	Thank you for your comment. We have not attempted to specify all different types of pain but asking about pain in general should cover these types of pain.

Royal Osteoporosis Society				severity and fracture possibility & risk, should also be assessed in relation to PAO.	
Pregnancy Sickness Support	Guideline	8	11	Add: Women with previous Hyperemesis Gravidarum should be advised that there is a risk of recurrence in future pregnancies. RCOG Green-top Guideline No. 69	Thank you for your comment. There are various issues that may be relevant to specific conditions but we are not covering this much detail in this guideline.
Public Health England - NHS Newborn and Infant Physical Examination Screening Programme	Guideline	14	22	hips: symmetry of the limbs and skin folds (perform Barlow and 22 Ortolani's manoeuvres) After national consultation reference to skin folds as screen positive criteria has now been removed in national guidance. Could the link to national NIPE screening clinical guidance be added to ensure contemporaneous access to information ? https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook	Thank you for your comment. We have taken out the reference to "skin folds". We have also added a reference to the NIPE screening programme as suggested.
Rotherham, Doncaster and South Humber NHS Trust	Evidence Review T	17	31	Perfect prep – more guidance needed	Thank you for your comment. The evidence review did not identify any themes pertaining to "perfect prep" therefore no information is provided in the evidence report.
Rotherham, Doncaster and South Humber NHS Trust	Guideline	9	30	This recommendation will be a challenging change in practice because as an organisation we often 1) do not find out about some women antenatally and 2) we do not get any information pertaining to discharge from midwifery services – This will likely cause more demand on services as Health visitors will have to make contact with the family on a regular basis so we find out	Thank you for your comment. Based on your and others' comments, we have now added a recommendation under the section 'Communication between healthcare professionals at transfer of care' that states that midwifery needs to ensure that transfer of care to health visitors is clearly communicated to the health visitors as well as to the woman/family. We have also

				when patients are discharged from services. It is also a concern that this may exclude partners and male caregivers who also need to be included in important public health messages. Most pertinent being that 70% of perpetrators in abusive head trauma (shaken baby) are males – fathers/male surrogates (Kesler et a 2008; Altman et al 2010) In addition there is emerging evidence to the likelihood of postnatal depression in fathers.	included a reference to the NICE guideline on child abuse and neglect. The focus of the guideline is postnatal care of the women and babies and while we recognise the importance of the wellbeing of partners/fathers, this is not in the remit of this guideline.
Rotherham, Doncaster and South Humber NHS Trust	Guideline	10	3	Again the added visit for ladies that do not get an antenatal will be a challenge in practice regards capacity, as the timings between the new birth visit, the additional visit and the 6-8 week contact will be very short.	Thank you for your comment. An added early postnatal visit would only be considered in the exceptional case that an antenatal visit has not been arranged. The antenatal visit should happen and in those cases where it hasn't happened, arranging it after the birth should not add to resources that should be in place already. We have also recommended spreading the postnatal visit more which should mean that the timings between visits are not too short in case an early visit is warranted.
Royal College of Midwives	Guideline	004 005	003 - 011 001 - 006	Timing of transfer home. This section is limited in terms of assessments recommended (i.e. a woman's bladder function and infant's passing of meconium) and can be challenged by pressures on NHS Trusts to tailor inpatient duration of stay to reflect a woman's or her infant's health and well-being. This will require resources in the in-patient services and physical spaces. There are other important aspects of women's health and recovery prior to transfer (i.e. perineal trauma/wound healing/advice on pelvic floor muscle	Thank you for your comment. The recommendation in this section does not list all the various aspects of woman's health that should be assessed, instead it refers to recommendations about the assessment of the woman's health which cover various aspects including perineal healing and wound healing. Based on stakeholder feedback, we have added advice around pelvic floor exercised to the guideline. We did not specifically mention giving women an opportunity to talk about her birth experience in this section either, but in a subsequent

				exercises (as recommended in the NHS Long Term Plan) that should be included as initiation of care plan transferred to primary care. The recommendation to give the woman the opportunity to talk about her birth experience, and provide information about relevant support services, if appropriate should be included in the 'timing of transfer home'. A research question addressing the impact of duration of inpatient stay on readmission rates of women and infants is required.	section we state that at each postnatal contact, this should be provided. ****A research recommendation was made about how the length of postpartum stay and the timing of the first midwife visit after transfer of care affects unplanned or emergency health contacts for women and babies.
Royal College of Midwives	Guideline	5	007 - 012	Re first midwife contact following transfer of care – please clarify if this should be in person (face to face) for all women	Thank you for your comment. We have revised the wording to explicitly state this should be face to face.
Royal College of Midwives	Guideline	6	007 - 009	There is currently no standard NHS postnatal discharge summary for GPs. Lack of this will continue poor communication patterns and short-sightedness in supporting on digital health and continuity of care between secondary and primary care. A recommendation needs to be strengthened addressing future proof care planning. ensuring issues relevant to a woman's pregnancy/medical history being communicated to the woman's GP.	Thank you for your comment. This is part of the reason why this recommendation was made and we think the recommendation addresses the issue by setting standards to what information should be communicated between secondary and primary care and between different teams. We have added to the recommendation that information about plan of ongoing care and long-term management should be shared.
Royal College of Midwives	Guideline	8	005 - 008	Make it clear that asking women also includes their perception of additional support and care. Currently it appears questions are asked for the health professional to make a clinical assessment for their management plan.	Thank you for your comment. The recommendation states that further care should be provided as needed, therefore we think this point is covered. We have also added a recommendations about providing information about what support is available and who to contact if there are any concerns at different stages.

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Royal College of Midwives	Guideline	10	011 - 014	It is disappointing that the postnatal period continues be defined as limited clinical 6 – 8 weeks. This lack understanding or support of the life cycle approach in 'women's health'. Should women's health needs have to be 'fitted' in with an infant check when evidence shows women experience health problems which persist well beyond 6-8 weeks, and that women value a consultation for their own health?	Thank you for your comment. The postnatal period continues beyond the first 8 weeks, however, this guideline focuses on the most critical first weeks after birth. The expectation is that if there are concerns at the 6-8 week assessment, appropriate plans or referrals about ongoing care are made.
Royal College of Midwives	Guideline	11	004 - 006	Re thromboprophylaxis. Would the RCOG Green Top Guideline reference 37a be a better reference or NICE guideline references only.	Thank you for your suggestion, with which the committee agree. In the final version of the guideline, this recommendation now cross refers to both the NICE and RCOG guidelines.
Royal College of Midwives	Guideline	12	007 - 011	From a formatting perspective, should persistent perineal pain be discussed before acute postnatal perineal pain? It is not logical to commence with a potential association between prolonged and severe perineal pain and depression. Associations with mental health may not just be a result of pain. All women who had a vaginal birth should be asked about symptoms of anal incontinence, given around 5% of women giving birth for the first time will sustain anal sphincter tears. Overall incidence is around 3%. The issue may be more complex than linking severe perineal pain with mental health problems – there may be also PTSD or mental health trauma following traumatic physical birth.	Thank you for your comment. The committee agree with your points about these complexities and have made the suggested change to the ordering of the recommendations in the final version of the guideline.
Royal College of Midwives	Guideline	13	011 - 013	This recommendation needs a definition of severity perineal breakdown to require urgent care.	Thank you for your comment. The committee's view is that any perineal wound breakdown requires urgent care.

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Royal College of Midwives	Guideline	13	General	'adverse childhood experiences' is a broad and vague concept	Thank you for your comment. We did not wish to be too specific here as there are various situations where bonding might be challenging due to childhood experiences.
Royal College of Midwives	Guideline	18	011 - 016	Some of the advice is confusing throughout the page as signposting to newborn care and under 5s, needs clarity and focus.	Thank you for your comment. Some of the NICE guidelines that cover new-borns also cover older children as well, which is why the guidelines being signposted include a broader age range than the postnatal care guideline.
Royal College of Midwives	Guideline	23	009 - 030	Discussing/advice re maternal medication is lacking – women who are on anti-depressants, anti-hypertensive medication or taking pain relief. Reference can be found related (sign-posted) to another NICE guideline i.e. epilepsy or MHRA advice. There is an increased focus on medicines during breastfeeding which should be reflected.	Thank you for your comment. The committee agreed to add a bullet point to this recommendation, which now makes reference to safe medicine use when breastfeeding.
Royal College of Midwives	Guideline	23	020 - 021	Advice/demonstration of how to safely make a feed. Many women give expressed breast milk through bottles and they need to be able to do this safely as well, advice not just linked to formula feed.	Thank you for highlighting this. The committee agreed to edit this recommendation, which now mentions the safe storage and preparation of expressed breast milk.
Royal College of Midwives	Guideline	29	12	The research question relevant to this section is rather unclear 'What characteristics of perineal pain suggest the need for further evaluation'? What is this question aiming to address?	Thank you for your comment. Full details of the research recommendation are provided in the Appendix L of the relevant evidence review, which is accessible through the hyperlink below the aforementioned research recommendation.
Royal College of Midwives	Guideline	General	General	It is of note that many recommendations/areas of practice continue to have no supporting evidence-base but are based on expert consensus only. These can emphasise existing practice and care	Thank you for your comment. The committee agrees that there is limited clinical evidence base for many of the topics covered in this guideline. Without robust evidence, it is difficult to change existing practices. Again,

				delivery patterns rather than allow for and encourage innovation i.e. timelines for duration of midwifery contacts, postnatal discharge at 6-8 weeks etc are included in the guidance, yet these timings are not evidence-based and are seen not meet women's health care needs (see Bick et al, CMO for England Report 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/595439/CMO_annual_report_2014.pdf). The guideline is detailed in the provision of women's physical care, based on clinical assessments, linking to the other NICE guidelines for more information on conditions and recommendations. This could be supportive in interlinking several NICE guidance; however, it can present a risk in fragmentation of the care, not having a holistic approach re physical and psychological co-morbidity. This could be an opportunity to provide advice/information on how NICE guidelines covering relevant health issues women face postnatally can be combined to ensure all women get the right care, at the right time from the right person? Having to signpost across several guidelines to support a vital aspect of women's health compounds the fragmentation of care offered to women who have recently given birth.	The committee agrees that because various NICE guidelines cover different aspects of potentially relevant care in the postnatal period, the links between them may sometimes be difficult to navigate. The NICE pathways, available on the NICE website, try to facilitate this by bringing all guidance on a specific topic (in this case postnatal care) under one pathway. We hope this alternative way of presenting the guidance will be of use.
Royal College of Nursing	General	General	General	The Royal College Of Nursing (RCN) welcomes the invitation to comment on the NICE Postnatal Care Guideline. The RCN invited members who care for pregnant women to review the draft document on its	Thank you.

				behalf. The comments below, reflect the views of our reviewers.	
Royal College of Nursing	Guideline	1	5	Good to see the explanation for the terminology 'woman - mother' used throughout the document.	Thank you.
Royal College of Nursing	Guideline	14	1	Interesting and useful to see the Newborn Infant Physical Examination (NIPE) included.	Thank you.
Royal College of Nursing	Guideline	38	22	There were plenty of links to signpost practitioners to related topics for more in depth information. We, however, consider the section on “perineal pain” to be comprehensive and welcome the committee’s comment inspection as essential as well as asking the woman.	Thank you.
Royal College of Nursing	Guideline	General	General	The guidelines provide an essential tool to aid healthcare practitioners plan postnatal care effectively - currently women in maternity services have care transferred swiftly and in a variety of settings, so good information and communication paramount. As midwives we mostly continue to care for women 10 - 28 days postnatally, (not that long really and some circumstances however may permit longer). Clarity around the definition of postnatal care would also be useful.	Thank you for your comment. We assume that you mean clarity around the timeframe that this guideline covers. This guideline covers postnatal care up to 8 weeks after birth and this is stated in the context section of the guideline.
Royal College of Nursing	Guideline	General	General	The guideline demonstrates good practice, backed up with rationale for the recommendations with the appropriate evidence. Also, it is an aid for trusts planning postnatal care.	Thank you.

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Royal College of Nursing	Guideline	General	General	Most of the recommendations do not to have significant cost implications but one needs to bear in mind that effective implementation would be down to demographics of the area and demands on the service.	Thank you for your comment. The committee agrees this being the case and local considerations are needed.
Royal College of Obstetricians and Gynaecologists	Guideline	16	001 - 013	Immediately after the bed sharing section, I think there should be a specific section (including statistics of cot death) on risks of smoking. I think this is as important as Bed Sharing, and also given the Saving Babies Lives Care Bundle Document.	Thank you for your comment. This issue was not in the scope of this guideline as such and has therefore not been reviewed, however, we have made references to smoking in various parts of the guideline, including about providing information about the importance of maintaining a smoke-free environment for the baby (added after stakeholder comments) and references to the NICE guideline on smoking: stopping in pregnancy and after childbirth.
Royal College of Obstetricians and Gynaecologists	Guideline	20	011 - 012	I am pro breastfeeding. It pains me to say the following. Stating here that the benefits of BF only should be explained to the woman is biased. There are pros and cons of BF and pro and cons of artificial feeding. Only giving the pros of BF and the cons of artificial feeding is only half the story and would lead the woman to make an apparently informed choice only rather than fully informed. It could be argued that writing the statement to say 'misled the woman about her options for feeding in favour of BF' is effectively synonymous with what is written currently.	Thank you for your comment. We have made some revisions to the feeding sections based on stakeholder feedback. For example, the recommendation you are referring to has been combined with the previous recommendation and we have taken out "explain to women". We have also made a reference there to a later recommendation where various other information related to breastfeeding is provided which should be discussed, including some of the potentially less positive aspects of it, such as pain when breastfeeding, complications such as mastitis and breast abscess and how to manage fatigue when breastfeeding. Similarly, we do not think that only cons of formula feeding should be discussed but rather the differences between breastfeeding and formula feeding.

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Royal College of Obstetricians and Gynaecologists	Guideline	General	General	I was surprised to see that there was no mention nor reference to postnatal contraception in this guideline. It is common in NICE guidance to be referred to other guidelines or sources of information as appropriate. This doesn't seem to have been the case here. Hopefully more women will have the contraception of their choice in place before leaving their place of birth. For those who were not offered this, or were undecided, this guideline is the ideal place to reinforce this message. Combining with the domiciliary visits would reduce number of appointments re: covid.	Thank you for your comment. Contraceptive care or services are not covered by this guideline as stated in the scope of the guideline. However, we include contraception as one of the topics for discussion with the woman at the postnatal contacts.
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	There is no section on bereavement care after fetal loss. This is an important area of postnatal care and should include recommendations on communication, suppression of lactation and psychological support.	Thank you for your comment. This topic was not in the scope of this guideline so we have not addressed it, although we have covered lactation suppression which may be relevant.
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	The COVID guidance from RCOG has been highlighted in the document and I think this is sufficient. Advice will change and the NICE guidance will therefore need to link to the most updated version.	Thank you for your comment. The website which we have linked to is the landing page on the RCOG website that include Covid-19 related information and should contain the most recent version of the guidance although we have no control over RCOG changing the content of this landing page.
Royal College of Obstetricians and Gynaecologists	Guideline	General	General	This document is comprehensive and reads very clearly.	Thank you.
Royal College of Paediatrics and Child Health	EIA	1.0.7 DOC EIA (2019)	5	The equality impact assessment refers to the MBRRACE-UK report findings that Black women are 5 times more likely to die in pregnancy, intrapartum and postnatal period compared to white women. Given this	Thank you for your comment. The committee agrees that more could and should be done to address this huge disparity. This topic was not included in the scope of this guideline so evidence on this was not reviewed so it is

				disproportionate inequality in health outcomes, the expectation would be for a stronger, more robust response to addressing this than is stated in this report. Specific targeted intervention for identified high risk groups is essential. This intention is not strongly conveyed in this equality impact assessment. The recommendation to tailor care to the individual needs of women does not go far enough to address this. Tailored care is a basic tenant of good medical practice which everyone should be doing anyway and despite this, Black women are 5 times more likely to die in pregnancy as compared with white women. This will only be definitively addressed if bold and courageous guidelines are made which are then implemented widely into clinical practice.	difficult to know without reviewing the evidence what interventions would be most effective in tackling this issue. Although, the committee discussed that the underlying causes behind these disparities likely go beyond issues that can be addressed in clinical practice alone. The committee thought it is important that healthcare professionals are aware of the increased risk of mortality for women and babies (as reported by the recent MBRRACE-UK reports on maternal as well as perinatal mortality) from black and minority ethnic background and from deprived areas. Therefore, the committee added a recommendation highlighting the disparities in maternal and neonatal mortality rates between different groups. Because of the increased risk, closer monitoring may be needed and threshold for further action might need to be lowered.
Royal College of Paediatrics and Child Health	Guideline	4	005 - 013	The guideline states: 'Before transfer from the maternity unit to home care: assess the woman's health (see recommendations 1.2.2 and 1.2.3) assess the woman's bladder function by measuring the volume of the first void after giving birth assess her baby's health (physical check and general behaviour check)' The statement refers to the last line regarding the assessment of the baby's health. The reviewer could find no further detail and noted that it isn't something that always happens if mothers have early discharge. What is anticipated with regard to	Thank you for your comment. We have revised the wording of the recommendation. What is meant is a basic physical inspection and observation by the clinician, not a full examination.

				this needs to be clear, is it a full examination or just a few questions to mother?	
Royal College of Paediatrics and Child Health	Guideline	14	001 - 024	Please note that skin folds are no longer considered a reliable sign of underlying DDH and as such this sign has been removed from the list of risk factors in the NIPE handbook. Would the GDG consider replacing with the wording 'hips: symmetry of leg length and level of knees when hips and knees are bilaterally flexed (perform etc…) to mirror PHE advice.	Thank you for your comment. We have removed "skin folds" from the recommendation, however, the additional detail suggested has not been included because the guideline is not attempting to provide the detail of a text book.
Royal College of Paediatrics and Child Health	Guideline	15	005 - 006	Item refers to carrying out the newborn hearing screen but follows on from examination etc. of the baby at 72 hours and at 6-8 weeks. The position of the reference to the hearing screen implies that it can be done at 72 hours or be considered at 6-8 weeks. The screen should be done prior to discharge from hospital care, (or as soon as can be arranged). It is often done prior to the first physical exam and should occur before 4-5 weeks (as per the relevant NICE guidance). There is an opportunity to complete before 3 months, but early screen and onward diagnostic testing should be promoted. Perhaps there should be a statement about checking that the screen has been done by whoever completes the 72 hour and 6-8-week assessments?	Thank you for your comment. We think that referring to the new-born hearing screening programme is sufficient to ensure that it is done appropriately.
Royal College of Paediatrics and Child Health	Guideline	General	General	It was noted that this is a very long guideline which has multiple links to other documents.	Thank you for your comment. Postnatal care is a large topic so there are quite a lot of recommendations. Various other NICE guidelines also cover many issues related to it so there are undoubtedly quite a lot of

					references to other guideline. However, we hope that the published web version of the guideline as well as the NICE pathway that is updated will make it easier to navigate.
Royal College of Paediatrics and Child Health	Guideline	General	General	The reviewer believed the guideline to contain very comprehensive and useful advice.	Thank you.
Royal College of Paediatrics and Child Health	Guideline	General	General	The reviewer was happy with the draft guideline.	Thank you.
Small Steps, Big Changes	Evidence Review F	General	General	We welcome this review and the recognition that postnatal care is a period of both physical and psychological change. However the proposed content appears to miss an opportunity to consider the importance of fathers' and his needs during this time. We would like to see a focus on both fathers and mothers. We recommend that clinicians should seek to give important advice and information to both parents equally at every contact. Therefore we suggest the target population is extended to include both fathers and mothers who have had at least one baby at term. The list of proposed topics to be included for the contact points should be extended to include an assessment and where needed; a follow up of care to support fathers' needs, physically and emotionally following the birth of a new baby. The language used in the proposed NICE guidance underplays the father as an equal parent. Whilst there is a mention of checking that the woman has adequate support from her partner and/or family, we would recommend that fathers are also seen as	Thank you for your comment. The committee discussed at length your point about the importance of considering fathers and their needs. As a result they made a number of changes to recommendations, for example a section now renamed as 'principles of care', which refers in greater detail to the involvement of fathers and added emphasis on communication with fathers, particularly as this relates to the care of the baby, including the provision of information about feeding. In terms of the physical and emotional needs of fathers following birth, these are not specifically within the scope of the guideline, which focuses on the postnatal care of women and babies and therefore none of the evidence reviews focussed on father's physical and emotional needs. Similarly in relation to your final point, unfortunately this would be beyond the scope of the guideline, which focuses on routine postnatal care and specifically excludes specialist care needed by women or babies resulting from complications before or during birth. Care before or during birth is

				parents in their own right with individual needs for support that should be considered during the postnatal period through a fathers' assessment. Finally, recognition that parents will need support in the postnatal period from clinicians when a baby has been miscarried or died should be considered. This is a period of immense distress, so prevention of longer term trauma should be included as a topic in this guidance; although we acknowledge that this might be covered in separate guidance from NICE.	also excluded (except where it relates to infant feeding).
Small Steps, Big Changes	Evidence Review G	General	General	Everett et al. (2006) identified a need for clinicians to routinely address the health behaviour of expectant and new fathers. In their study 49.3% smoked; 30.4% had engaged recently in recent hazardous drinking; 27.5% had very low physical activity levels; 94.9% had an at-risk fruit/vegetable intake; and 42% a weight-related health risk. Both parents being physically strong and healthy following the birth of a baby will inevitably provide the best start to life for the baby. In 2015, Public Health England conducted a rapid review to update evidence for the Healthy Child Programme 0–5; this stressed the need to support fathers particularly in the transition to fatherhood during both the antenatal and postnatal period. Therefore we would like to see that recommendation 1.2 is extended to include information about the postnatal health of fathers/partners too. Suggested topics about the postnatal health of fathers, that clinicians could provide might include; stress, anxiety,	Thank you for your comment. The evidence review aims to determine how and when information should be given to mothers and their partners or relatives about the postnatal health of the mother. The postnatal health of the father is not included in the remit of this guideline, therefore no recommendations can be made in relation to paternal health.

				adjustment, depression, coping, sleep, eating & exercise. **********In addition, providing information postnatally on maternal and paternal mental health needs to be a priority. Giallo et al. (2012) analysed over 3500 fathers and found 30-50% of these dads were affected by poor mental health. Volling et al. (2002) highlighted how a father's depression can have an independent effect (to any mental illness experienced by the mother) on the family. If there are siblings and dad is depressed he will be emotionally unavailable for the older children and unable to meet their needs or cope with the arrival of a new baby. We suggest where possible both caregivers need to understand the signs of mental illness that can arise for both mothers and fathers during this period. Information to signpost either or both parents to seek advice and support should then be offered.	
Small Steps, Big Changes	Evidence Review L2	General	General	We are strong advocates for infant mental health. The1001 critical days movement suggests too many new babies experience complex relationship difficulties with their primary carers. Without specialised help these unresolved problems can affect future outcomes and in the most severe cases, can lead to a child being taken into care. Therefore alongside recommendation 1.4, we would push for the proposed NICE guidance to also include the maintenance of infant mental health. We recognise that some healthcare clinicians, who see families during this postnatal period, can lack the	Thank you for your comment. Evidence review L2 assesses the accuracy of scoring systems to identify serious illness in young babies, thus recommendations are limited to the remit of this review.

				confidence, knowledge and/or experience in assessing and identifying infant mental health needs. Therefore we recommend the new guidance includes pathways for clinicians to receive relevant training and competencies. An additional contact point for the observation of baby states and attachment, along with an accompanying scoring system is also suggested.	
Small Steps, Big Changes	Evidence Review O	General	General	It is really pleasing to see that emotional attachment is included in the NICE consultation for children and families. We recommend that the language used is more father inclusive. The role of the father/partner should receive equal status throughout the guidance. Emotional attachment with both the mother and the father will have a more significant impact on the emotional wellbeing of the child, than focusing just on 'women and babies'. The NICE Social and Emotional Wellbeing report (2012) recommends that Maternity, Health and Early Years workers should, where possible, focus on developing the father–child relationship as part of an approach that involves the whole family. This includes getting the father involved in any way possible. We recommend routine assessment of healthy relationships between all family members. This should include the attachment between the mother and baby, attachment between father and baby, and the relationship between the couple. The suggested outcomes outlined in this section of the proposed guidance are focused on mothers. We would suggest there needs to	Thank you for your comment. We acknowledge that there are other sources of attachment for babies other than the mother e.g. father, mother's partner, other family members. However, the committee agreed to focus the review protocol to mother and baby attachment, thus only studies pertaining to this relationship are included in the review. That being said, we will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.

				be parity for fathers and any interventions need to explicitly state how fathers can also support or be supported with attachment.	
Small Steps, Big Changes	Evidence Review P	General	General	We suggest that recommendation 1.3 should explicitly state the importance of the role of the father in the initiation and maintenance of breastfeeding. Example interventions here could include; encouraging skin to skin contact between the father and the baby, training fathers to become breastfeeding peer supporters, and fathers receiving information about the difficulties which can be experienced during breastfeeding and how they can best support their partners.	Thank you for your comment. The recommendations under 1.3 of the draft guideline relate to the assessment and care of the baby so your comments probably refer to the recommendations under section 1.5 about planning and managing babies' feeding. The recommendations in this section are informed partly by review P but also largely on the basis of the qualitative reviews on breastfeeding facilitators and barriers and breastfeeding information and support. The recommendations about planning and managing babies' feeding do recognise the role of both parents and of partners, for example giving information to partners about how they can support the woman to breastfeed, including the value of their involvement and support and how they (the partner) can comfort and bond with the baby. Another recommendation also states that breastfeeding care should involve providing information for partners about breastfeeding and how best to support breastfeeding women. In relation to skin to skin contact, the committee recommended (in a different section of the guideline) that parents (not just mothers) should be encouraged to spend time with their baby as a way of promoting emotional attachment, including skin to skin contact. Also, that if a baby is being bottle fed, then support for formula feeding should include how to bond

					with the baby through skin to skin contact and eye contact and so on.
Small Steps, Big Changes	General	General	General	New NICE guidance on postnatal care is welcomed by us as we believe early intervention, and indeed prevention, should be at the heart of services working with children and families, including all Healthcare providers. Current strategic aims for us include increasing father inclusive practice, supporting breastfeeding rates, the importance of services for infant mental health, and the promotion of healthy parent-infant relationships and attachment. Many of our priorities have been mentioned in the proposed NICE guidance. However we feel even more is possible to support families holistically through early intervention.	Thank you for your comment.
Small Steps, Big Changes	General	General	General	In summary, we see the postnatal period as a vital period for professionals to support families transitioning to parenthood or welcoming additional babies into their lives. According to Unicef, World Bank and World Health Organisation (2018) “The period from pregnancy to age three is when children are most susceptible to environmental influences. Investing in this period is one of the most efficient and effective ways to help eliminate extreme poverty and inequality, boost shared prosperity, and create the human capital needed for economies to diversify and grow.” We therefore recommend that Healthcare professionals (from Midwifery and Health Visiting services) who have the most touch points with parents	Thank you for your comment. ****The remit of the guideline is the postnatal care of the woman and her baby, however, we have considered the role of the partners/fathers/other parental caregivers in the guideline. For example, the recommendations on promoting emotional attachment and baby's feeding often refer to parents as we recognise the role that other parental caregivers play in these areas. The committee have also revised the recommendations based on stakeholder comments so that it is clearer where we mean the woman/mother, and where we mean the parents, or the partner. ****We did not review evidence on assessing parent-infant relationships or baby

				during the postnatal period, should be supported to ensure their contacts with families are able to be widened in content and outcomes. We propose that the new guidance from NICE includes the following: Father inclusive practice where fathers/partners are seen as equal caregivers Assessment and support for infant mental health Assessment and support to enable healthy parent-infant relationships Support and signposting for clinicians to feel competent assessing baby states/attachment Assessment and support for fathers/partners mental and physical wellbeing following the birth of a baby	states/attachment, however, the section on promoting emotional attachment touches upon these topics and recognises that some parents might need additional support when building parent-infant relationships.
Small Steps, Big Changes	Guideline	7	23	1.1.10 What about pregnant women with learning difficulties or mental health concerns, and their partners.	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The groups listed in your comment may well also be relevant, however, these are not covered by the above NICE guideline.
Small Steps, Big Changes	Guideline	9	3	1.2.3 Talks about breast comfort and inflammation, should also include any breast discomfort/pain when *breastfeeding*.	Thank you for your comment. Pain when breastfeeding in specifically covered in the breastfeeding section, however, we believe assessment of this would be covered by the asking the woman about pain, and nipple and breast comfort.
Small Steps, Big Changes	Guideline	10	6	1.2.5 What about fathers/birth partners	Thank you for your comment. The focus of this guideline is the postnatal care of the women and babies and while we recognise the importance of partners'/fathers' experience and well being, this is outside the remit of this guideline. However, we have

					made a reference to the NICE guideline on antenatal and postnatal mental health which includes a section about birth trauma and these recommendations include taking into account the effect on the partner.
Small Steps, Big Changes	Guideline	12	8	1.2.15 Information about prolapse? Referral to services and info about continence issues or pelvic floor health. Diastasis recti.	Thank you for your comment. The committee considered your suggestion and although they decided not to make a specific change to this recommendation they did revise another recommendation, which now refers to the importance of pelvic floor exercises and when to seek help in this context. In addition, there was already a recommendation to examine bladder and bowel function and a section specifically about perineal health.
Small Steps, Big Changes	Guideline	13	19	1.3.2 It may also indicate feeding issues/inefficient milk transfer. Need to have a feeding assessment – for both breastfed or bottle fed infants.	Thank you for your comment. Feeding assessment is indeed an important aspect and in the case of not passing meconium, this would be captured when seeking medical advice.
Small Steps, Big Changes	Guideline	16	9	1.3.13 Clarify that this is due to the risk of SIDS, where is the recommendation for infant to sleep in the same room and in close proximity to parents for all sleep for at least the first 6 months of life.	Thank you for your comment. The rationale and impact section (and evidence review N) explain the association with SIDS. We did not review evidence on safer sleeping practices in general (apart from bed sharing/co-sleeping) but are aware of established guidance and have added this to a recommendation about providing information to parents about caring for their baby. In the rationale and impact section we provide some examples of sources for this guidance.

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Small Steps, Big Changes	Guideline	17	5	1.3.15 Specify that father can/should be involved in the day to day care of the infant	Thank you for your comment. We have not specified this but these recommendations are aimed at all/both parents, including fathers.
Small Steps, Big Changes	Guideline	17	10	1.3.16 Mismatch in expectations versus reality of normal infant behaviour/need for constant care and contact, lack of day to day and social support.	Thank you for your comment. The committee agrees with these issues being potentially challenging factors that may have an effect on bonding and emotional attachment, however, the list is not attempting to be exhaustive but point to some of the most common types of challenges in the postnatal period. Demands of parenthood, for example, could encompass many of the issues you mention.
Small Steps, Big Changes	Guideline	20	3	1.5 Conversations about infant feeding in the antenatal period are necessary to explore both parents feelings and provides opportunity to offer support before the baby is born.	Thank you for your comment. We have revised the wording so that in the 'General principles about babies' feeding' section we talk about parents, not just the woman.
Small Steps, Big Changes	Guideline	20	5	1.5.1 Highlight the importance of responsive feeding whether breast or bottle feeding	Thank you for your comment. Responsive feeding has been highlighted in the section on breastfeeding and on formula feeding and the definition of responsive feeding used by the guideline covers both contexts.
Small Steps, Big Changes	Guideline	20	13	1.5.3 Should be discussed in terms of risk to both baby and mother, women are entitled to be properly informed to make their decision – after mother has made her decision she should be fully supported however she feeds her baby.	Thank you for your comment. We recommend that breastfeeding complications (such as mastitis or breast abscess) are also discussed and we have now made a reference to this recommendation from the recommendation you are commenting on.
Small Steps, Big Changes	Guideline	21	10	1.5.6 Inform women and their partners.	Thank you for your comment. We have made the suggested change.

Small Steps, Big Changes	Guideline	21	13	1.5.7 Knowledge of presentation of feeding problems on different skin tones (i.e. mastitis does not present with redness on dark skin)	Thank you for your comment. This is a very specific issue related to the bullet about common problems in breastfeeding, and the recommendation is not attempting to capture this type of detail.
Small Steps, Big Changes	Guideline	22	3	1.5.9 Engage with partners to show them how they can also support breastfeeding women- both with feeding challenges and with the day to day feeding	Thank you for your comment. There is another recommendation about how partners can support the woman to breastfeed so we think this issue is covered in that.
Small Steps, Big Changes	Guideline	22	13	1.5.10 Provide or refer to skilled support if baby has a health/physical issue – e.g. poor muscle tone, downs syndrome, cleft palate	Thank you for your comment. We have added to the section on assessing breastfeeding, that if there are ongoing concerns, referral to additional support should be considered.
Small Steps, Big Changes	Guideline	22	13	1.5.10 Info about local services and support as well as nationally available helplines and information	Thank you for your comment. We have added to the section on assessing breastfeeding, that if there are ongoing concerns, referral to additional support (such as peer support) should be considered.
Small Steps, Big Changes	Guideline	24	16	1.5.16 Other practices e.g. scheduling feeding (making baby wait to feed), night time behaviour and feeding (inappropriate sleep training), use of formula supplementation	Thank you for your comment. We provide some examples but the list is not comprehensive and the issues you suggest might be options for some. These issues would also be captured in the other recommendations about discussions around breastfeeding.
Small Steps, Big Changes	Guideline	26	8	1.5.21 …and managing supply during transition to avoid complications such as engorgement and mastitis.	Thank you for your comment. Issues related to lactation suppression and potential issues with engorgement are covered in other sections of the guideline.
Southern Health and Social Care Trust	Guideline	8	5	Could this be changed to read ‘At each postnatal contact, ask the woman and the other parent, if present, about their general health and emotional wellbeing and whether they have any concerns. Having a “think	Thank you for your comment. We recognise the importance of partner's wellbeing, however, the focus of this guideline is on the health and wellbeing of the mother and the baby. Partners should be involved according

				family approach" is important for all practitioners and helps to assess level of need and risks https://www.scie.org.uk/publications/guides/guide30/summary.asp Keeping Fathers/Partners/Other parents in the conversation and including them in the care of their baby is important too. https://dadmatters.org.uk/wp-content/uploads/2020/09/MARK_WILLIAMS_FATHERS_REACHING_OUT_PMH_REPORT10_SEP_2020-2.pdf	to the woman's wishes and this is stated in the guideline.
Southern Health and Social Care Trust	Guideline	8	22	Consider adding in assessment of emotional wellbeing including perinatal mental health red flags Recent significant change in mental state or emergence of new symptoms, new thoughts or acts of violent self-harm, new and persistent expressions of incompetency as a mother or estrangement from the infant https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/~/media/8BB0A8DDBFF045BAB32F48B607773A69.ashx Particularly as maternal suicide is the second largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy and remains the leading cause of direct deaths occurring within a year after the end of pregnancy (MBRACE report) https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK Maternal Report 2019 - WEB VERSION.pdf	Thank you for your comment. Postnatal mental health is covered by the NICE guideline on antenatal and postnatal mental health and no evidence on this topic was reviewed for this guideline therefore no detailed recommendations have been made but instead we refer to the other NICE guideline.

Southern Health and Social Care Trust	Guideline	15	12	Consider adding in a section about emotional wellbeing of infant and brain development because the first 1001 days of life, from conception to age 2, is a time of unique opportunity and vulnerability. It is a period of particularly rapid growth, when the foundations for later development are laid. During this time, babies' brains are shaped by the interactions they have with their parents. https://parentinfantfoundation.org.uk/wp-content/uploads/2019/09/PIPUK-Rare-Jewels-FINAL.pdf	Thank you for your comment. We think that the general assessment of the wellbeing of the baby, woman and the family life as well as discussion around emotional attachment will give indication to any potential concerns around the baby's emotional wellbeing and development and appropriate referrals and follow-up would be arranged as with any other concern. Specialist care as such as outside the remit of this guideline.
Southern Health and Social Care Trust	Guideline	27	4	Consider expanding this section to highlight the importance of infant brain development. Consider the importance of professionals observing and assessing parent-child interactions and relationships. Consider the use of evidence based interventions that professionals can provide to improve the quality of early interactions. https://parentinfantfoundation.org.uk/wp-content/uploads/2019/09/PIPUK-Rare-Jewels-FINAL.pdf	Thank you for your comment. We have made revisions in light of your comment but since it is only intended as a definition we have tried to keep it short without going into too much detail. Assessing parent-infant relationship was not part of the scope for this guideline so evidence on it has not been reviewed. However, we think that generally the observations and discussions the healthcare professionals have with the families during their visits would likely include assessments of the relationship as well even if not specifically mentioned. We looked for evidence on interventions to promote emotional attachment but the evidence base was very limited. Please see evidence review O for details. Thank you for sharing the link to the report about specialised parent-infant teams in the UK.

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Sussex Community NHS Foundation Trust	Evidence review B	13	11	We agree good communication between professional groups is essential. Strongly support strengthening information sharing between professional groups starting in antenatal period. BUT Consultation does not make clear who professional or community groups are and as vagueness risks nothing improving. Do not agree with committee decision not to make recommendations for how trusts share information i.e. electronic for all and verbally for those with 'red flags'. Guidance should recommend all trusts have agreements and processes in place for seamless information transfer combing electronic and verbal, in addition to recommendations around the content. Whilst support verbal communication for vulnerable women and babies, this has to be backed up with electronic communications, otherwise risks will not happen as individuals are busy or not available, or not clear who to talk to.	Thank you for your comment. The committee recognised that they did not have the basis on which to recommend that health trusts adopt specific technological solutions because none of the reviews had been designed to locate evidence about their effectiveness and such recommendations would incur a significant resource impact. They did however agree that the evidence presented for review B supported their recommendation for effective and prompt communication between professionals when women transfer between services, for example from secondary to primary care. They also provided a list of relevant information that should be shared and since this is worded as a strong recommendation in NICE terms the committee are confident trusts will respond.
Sussex Community NHS Foundation Trust	Evidence Review D	9	021 - 031	The big change for health visitors is potential change to timing of first post-natal contact to: "take place between 7 to 14 days after discharge from midwifery care, which would usually mean 17 and 28 days after birth because the discharge from midwifery care usually happens between 10 to 14 days after birth." We STRONGLY agree with the recommendation – the review makes very good reference to why the change is being proposed, in addition it would mean make it less likely that babies with abnormal prolonged jaundice will fall through the gap in seeing a professional after day 14, or for too	Thank you for your support for this recommendation. We have added a recommendation about ensuring that midwifery communicates the transfer of care to health visitors clearly to the health visitors and the woman/family.

				many babies being subjected to unnecessary blood testing as HVs would be able to assess the baby at a time when referral for blood test appropriate. The pitfall in the change is knowing when the midwife as discharged and should be part of the recommendation for evidence review B 'Information Transfer'.	
Sussex Community NHS Foundation Trust	Evidence Review E	9	005 - 016	The evidence makes reference to routine postnatal assessment at 6-8 weeks but does not acknowledge that currently GPs see women and babies at 6-8 weeks and so do health visitors. It would make better sense for the timing of the health visiting review to be between 10-14 weeks to assess maternal mental health. The current system is confusing for families and another example of doubling up of appointments much like the timing of midwifery discharge and health visitor new birth visit between day 10-14 considered in review D.	Thank you for your comment. The remit of the guideline includes postnatal care up to 8 weeks after birth, therefore the committee were unable to write recommendations for later assessment as suggested.
Sussex Community NHS Foundation Trust	Evidence Review F	12	34	Where severe mental health problems are indicated by professional observation and/or relevant assessment tool, women should be referred for further assessment and a safety plan agreed.	Thank you for your comment. The text to which you refer is actually some of the data extracted from the included guidelines within that evidence review. These were discussed by the committee and considered as a basis for making recommendations. The committee did not use these statements verbatim in the guideline and instead made a recommendation that at each postnatal contact, the woman's psychological and emotional wellbeing should be assessed. In doing so the recommendations in the NICE guideline on antenatal and postnatal mental should be followed. The recommendation

					also states that further assessment and follow up should be arranged if there are concerns.
Sussex Community NHS Foundation Trust	Evidence Review F	12	39	Women thought to be suffering from birth trauma should be referred to relevant services for additional assessment and support (in accordance with Birth Trauma Pathway)	Thank you for your comment. The text to which you refer is actually some of the data extracted from the included guidelines within that evidence review. These were discussed by the committee and considered as a basis for making recommendations. The committee did not use these statements verbatim in the guideline and instead made a recommendation that at each postnatal contact, the woman's psychological and emotional wellbeing should be assessed. In doing so the recommendations in the NICE guideline on antenatal and postnatal mental should be followed. The recommendation also states that further assessment and follow up should be arranged if there are concerns. In addition, the committee recommended that the woman should be given the opportunity to talk about her birth experience and that if it is appropriate then information about relevant support services should be provided.
Sussex Community NHS Foundation Trust	Evidence Review G	12	40	…thereby adopting a 'Watch Wait Wonder' approach Good to see the highlighted importance of giving information before the birth and preparation for parenthood. (Mothers consultation)	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review G	12	043 - 044	In addition to consideration for the woman's partner (or whoever supports her) to be aware of the importance of emotional attachment, we wold like to add that this is important so that they too can engage in	Thank you for your comment. The committee agree with you that parents - and not just mothers - should be aware of the importance of bonding and emotional attachment and have discussions about ways to promote

				similar positive interactions and can additionally support the woman	emotional attachment by bonding with their baby. To this end the committee made recommendations that parents (and not just mothers) should be given information about bonding and emotional attachment and that discussions with parents about the importance of bonding and emotional attachment should take place before and after birth. They also recommended that parents should be encouraged to promote emotional attachment through skin to skin contact, face to face interaction and responding appropriately to baby's cues.
Sussex Community NHS Foundation Trust	Evidence Review G	13	007 - 010	Re: traumatic birth or birth complications that could impact bonding and emotional attachment: WE would like add that Early identification and appropriate support is essential to minimise the impact on the developing attachment. Recognition of the fact that partners can also be significantly impacted is important and that they are equally able to access support if required.	Thank you for your comment. The committee are in agreement with you about the potential impact of traumatic birth on emotional attachment and the fact that support for partners is important in this context. In view of this they recommended discussions with parents (not just mothers) about the potentially challenging aspects of postnatal care that might affect emotional attachment and bonding and that practitioners should recognise that additional support to promote bonding and emotional attachment may be needed for some parents. In another section of the draft guideline the committee also recommended that at each postnatal care contact women should be given the opportunity to talk about their birth experience and be provided with relevant support and information.
Sussex Community NHS Foundation Trust	Evidence review H	General	General	We agree that the woman's psychological and emotional health should also be assessed at every contact. Review of	Thank you for your comment. Tools used for recognising mental health problems were excluded from this review because the NICE

				evidence only covered pain and constipation, would like to see review of tools used in assessing maternal mental health.	guideline on antenatal and postnatal mental health (CG192) already covers recognition of mental health problems in the postnatal period.
Sussex Community NHS Foundation Trust	Evidence Review K	General	General	Nothing to add	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review L	General	General	Not reviewed	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review L2	General	General	Not reviewed	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review M	General	General	Nothing to add	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review N	General	General	Nothing to add	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review O	General	General	Re: Parenting and emotional attachment. It suggests that Maternal emotional wellbeing should be assessed at 3-5days HV/MW 10-14 days 6/8 week and 16 weeks – in which case we would suggest it is recommended GP assesses at 6-8 weeks and Health Visitor at 16 weeks, as opposed to current model where GP and HV have separate appointments with mother at 6-8 weeks. It also suggests that there should be services commissioned to support attachment, baby massage/group based services covering five to thrive messages for parents to gain support – please be specific around commissioning around this from Healthy Child Programme or Early help services, or	Thank you for your comment. We are unclear where the health visitor assessment at 16 weeks comes from, as this is outside of the scope of the guideline (postnatal care up to 8 weeks after birth). We recognise that some parents/caregivers may need additional support, however considering the paucity of evidence for specific support and the potential resource impact we could not make strong specific recommendations for support interventions.

				both working together. Suggested that where there are issues with attachment, more intensive home visiting should be offered with appropriately trained nurse and video interaction, with adequate funding health visitors well placed to do this work	
Sussex Community NHS Foundation Trust	Evidence Review P	General	General	This evidence review supports recommendations 1.5.2, 1.5.4, 1.5.10, 1.5.11 and 1.5.12. Recommendations all relevant- nothing to add Questions 1-4 no extra comments	Thank you for your support for these recommendations.
Sussex Community NHS Foundation Trust	Evidence Review Q	General	General	Recommendation all relevant - no extra comments	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review R	General	General	Recommendation all relevant - Nothing to add Questions 1-4	Thank you for your comment.
Sussex Community NHS Foundation Trust	Evidence Review S	General	General	Make face-to-face breastfeeding support integral to the standard postnatal contacts for women who breastfeed: Can we add to continue this until breastfeeding is established and any problems have been addressed	Thank you for you comment. We are unclear what issue is being raised with this comment, as it is very similar to the recommendation "Make face-to-face breastfeeding support integral to the standard postnatal contacts for women who breastfeed. Continue this until breastfeeding is established and any problems have been addressed".
Sussex Community NHS Foundation Trust	Guideline	12	10	Please add advice on Smoking/alcohol and substance misuse	Thank you for your comment. We have revised the wording so that we specifically mention smoking, alcohol consumption and recreational drug use.
The Breastfeeding Network	Evidence Review P	009 – 010	General	Rational for dismantling the McFadden Systematic Review is understandable as you are looking at the impact over three time points but breastfeeding research is often underpowered so by splitting the studies you've weakened the evidence and lost sight	Thank you for your comment. The variables chosen for the meta-regression in review P actually represented the different intervention characteristics (or 'moderator variables') that the committee considered appropriate. They wanted to understand the impact of those

				of what might be effective. In the UK we have a rapid drop-off in the first 4 days, followed by the remainder of the first two weeks so this needs to be a significant focus of this guidance. The variables chosen are proxies for continuity of skilled care: number of contact visits – 0, 1, 2-3, 4-8 and 9+ how delivered – face-to-face on an individual basis, face-to-face in a group, remote, self-help duration of contact – contact with the intervention lasted less than 8 weeks, contact with the intervention lasted more than 8 weeks where the intervention was delivered – at the woman's home, in a healthcare setting or a combination of both home and healthcare setting. Other relevant variables include proactive vs reactive support, whether interventions have differing results depending on background prevalence rates. Other interventions where recommendations should fall within the scope of this NICE Guidance might include all contacts with BFI trained teams, and hospital practices such as uninterrupted skin-to-skin contact and timing of newborn weighings.	variables on the study effect size. They were not intended as proxies for continuity of skilled care but instead, important characteristics which might inform the nature of breast feeding interventions that the committee went on to recommend. You are right that other variables might influence effect sizes but the ones chosen were felt to be the most useful in terms of the nature of the data and the focus of the recommendations the committee hoped to make.
The Breastfeeding Network	Evidence Review P	203	Table 29	Cost of intervention There are many models. These are backed by The National Breastfeeding Helpline so a good use of practitioners time would be to explain how it works and how to make best use of the helpline.	Thank you for your comment. We agree, there are many models of providing interventions that promote breastfeeding. For the economic analysis, we selected to cost an intervention with elements that were shown to be effective, according to the guideline meta-analysis and meta-regression. However, we have done a sensitivity analysis where we tested the cost-

					effectiveness of different combinations of cost and effectiveness of the intervention (see Table 42 in evidence report P). However, as discussed on page 237, "it is not certain whether an intervention delivered exclusively by peer supporters would reach the effectiveness of an intervention led, or at least initiated, by health professionals." This is also true for the effectiveness of a helpline versus face-to-face support, either by a health professional or a peer. Information on breastfeeding including delivery of breastfeeding interventions were included in this review question, however no themes on information delivery on breastfeeding were identified in the included papers. Thus no specific recommendations were made with regards to specialist breastfeeding organisations.
The Breastfeeding Network	Evidence Review P	205	037 - 042	Health benefits over-estimated and therefore also cost savings. We reject this assertion. Researchers should consider the impact of approval bias, with the mother knowing the desired response of exclusive breastfeeding. This results in lower reduction in health outcomes. This guidance has not considered other health outcomes such as lower antibiotic use in infants, the toll on a mother's mental health from being unable to establish breastfeeding	Thank you for your comment. In the discussion section we provide a critical appraisal of the guideline economic analysis, assessing separately all model assumptions and data that informed the analysis. We have not stated that the economic analysis has overall overestimated the health benefits and cost-savings of the breastfeeding intervention. Some benefits may have been overestimated, some others may have been underestimated. In fact, page 238 describes aspects of the model which may have underestimated the cost-effectiveness of the breastfeeding intervention. The committee has considered carefully the strengths and limitations of the economic analysis, and the

					possible areas where benefits and cost-savings of breastfeeding interventions may have been over- or under-estimated. On pages 91-92, which is a summary of the committee's discussion, it is stated: "the committee noted that several other outcomes that are associated with breastfeeding, such as ovarian cancer in women [...] were not considered in the analysis. [...] Therefore, they noted that the analysis may have underestimated the cost-effectiveness of the breastfeeding intervention by omitting some important beneficial outcomes of breastfeeding. On the other hand, the committee was aware that, due to lack of more suitable data, the guideline economic analysis overestimated some of the modelled benefits [...]. The committee agreed that, on balance, the estimated ICER was reflective of the cost-effectiveness of the breastfeeding intervention, [...] and should be considered as such when making recommendations. In the specific section that you refer to, we do argue that the literature used to populate the economic model may have overestimated the clinical benefits of breastfeeding due to bias and unknown confounders, which, we believe is a fair criticism. Nevertheless, we acknowledge that there may be additional benefits of the breastfeeding intervention that had not been discussed in the consultation draft, and these have now been added on page 238.

The Breastfeeding Network	Evidence Review P	General	General	For the sections on topics related to feeding – breastfeeding, formula, teats and bottles, this NICE Guidance ought to be taking a child rights-based approach based on the Convention on the Rights of the Child (CRC). Article 24 recognises the right of the child to the enjoyment of the highest attainable standard of health … including …appropriate pre-natal and post-natal health care for mothers; Many elements including: "To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents" https://www.ohchr.org/en/professionalinterest/pages/crc.aspx Our concern with evidence review [P] is that it needs to have a more holistic view of health, particularly to include perinatal health and that support should be offered to help mothers gain confidence in feeding their babies so breastfeeding is sustainable beyond the first few weeks. The economic analysis includes costings for health professionals which might have been needed in the past but now all frontline staff caring for new mothers should have the skills to support	Thank you for your comment. The scope of this guideline was the postnatal period (first 8 weeks) after the birth and the committee are in agreement with you about the importance of taking a holistic approach to the health and wellbeing of babies and women during this time. They are also in agreement with you about the importance of not only initiating but also maintaining breastfeeding and this is reflected in the outcomes chosen for review P, which include initiation of breastfeeding, any breastfeeding up to 6 months and exclusive breastfeeding up to 6 months. The recommendations that the committee made on the basis of review P and also on the basis of the qualitative reviews on breastfeeding facilitators and barriers and breastfeeding information and support do aim to ensure a person centred, sensitive and non-judgemental approach to helping parents with this important area including provision of information about the advantages of breastfeeding - all with the aim of both initiating and maintaining breastfeeding. ********The intervention cost used in the economic analysis was estimated using elements of the intervention (and associated resource use) that were shown to be effective according to the guideline meta-analysis and meta-regression, supplemented by the committee's expert opinion on how intervention can be optimally provided within the NHS context. Even if the resource use costed at £59 per patient-related hour was replaced by peer supporters (costed at £20

				them however they are feeding their baby(ies). We need to get passed the stage of retrofitting support to maternity services – So remove the costs of £59 per patient-related hour, or use it to fund paid peer support and coordination of that service [Table 29]. The impact on the mothers mental health alone is priceless and yet is not costed – it will be hard but without it the costings are an underestimate. *Perinatal support, including breastfeeding and bottle feeding should be tailored for the needs of the community, commissioned to meet specific objectives, evaluated annually and developed to meet local needs.********In particular during COVID the intervention of most relevance is a combination of hospital education and support and ongoing remote support by the hospital team and the National Breastfeeding Helpline. Please contact Alison McFadden as we have been working with her in this systematic review.	per hour), this would result in an intervention cost of £45. We have done a 2-way sensitivity analysis where we have combined different potential costs and effectiveness of the intervention (table 42). At a cost of £45, and same effectiveness as the costed intervention (RR 1.19), the intervention would be just at the threshold of being cost-effective. However, as we discuss on page 237 "it is not certain whether an intervention delivered exclusively by peer supporters would reach the effectiveness of an intervention led, or at least initiated, by health professionals. Moreover, it is possible that the unit cost of a peer supporter is higher, if childcare costs are taken into account, meaning that an intervention cost as low as £40 may not be achievable even by provision of the intervention by a peer supporter offering 4 individual 30-minute sessions." We acknowledge that there may be additional benefits of the breastfeeding intervention that had not been discussed in the consultation draft, and these have now been added on page 238 of evidence report P. Regarding care provided during COVID, the guideline provides links to guidance by Royal College of Obstetricians and Gynaecologists for antenatal and postnatal services. No specific recommendations were made with regards to specialist breastfeeding organisations, because the qualitative reviews around breastfeeding did not identify any themes on information delivery.

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The Breastfeeding Network	Evidence Review P	General	General	Consider population level case studies such as in Tower Hamlets to understand the economic case for an integrated infant feeding service.	Thank you for your comment. Unfortunately the type of evidence you mentioned (population level case studies) does not fit the inclusion criteria for the protocol for this review question and therefore could not be considered as a part of the evidence base for making recommendations in the area of infant feeding.
The Breastfeeding Network	Evidence Review T	9	031 - 033	Fathers – can this heading be reworded to include partners and be a more general line as many will only read the heading.	Thank you for your comment. The recommendations for formula feeding in the guideline have used broader terms such as parents, partners, and family. However, as the evidence to support "theme 4: fathers are better able to support when formula feeding" is only based on 1 study of fathers, the use of fathers in the heading will remain unchanged .
The Breastfeeding Network	Evidence Review T	9	031 - 033	Questions relating to infant formula include – should NICE make a recommendation for newborns to have ready to feed infant formula in the first few weeks – gives the family time to learn how to make up feeds and also should reduce the potential for pathogenic bacteria in the formula. Other questions – portion size and inter-generational cultural beliefs about large feeds well spaced out contrast with a more response led approach – this is tension within families and leads to over-feeding and/ or wasted formula. Paced bottle feeding is included, it has become accepted practise but we are not aware of any evaluations of this practice. It can lead to babies taking a long time over their feed and may be a reason for slow weight gain.	Thank you for your comment. The review question doesn't address whether infant formula should be given, but rather if the woman choses to formula feed what information and support she finds beneficial. In view of this, it is outside the remit of the question to recommend that all new-borns should have infant formula in the first few weeks. Paced bottle feeding is still a relatively new concept for healthcare professionals and parents, therefore we would not consider this accepted practice. Paced bottle feeding arose through observations of distress in babies during bottle feeds, and ultrasound scanning with compromised babies, including those with tongue-tie, who struggle to cope with the fast flow of milk from a teat. Feeding more slowly

					is actually likely to lead to more of the feed being taken by the baby and a less “windy, colicky” baby, so rather than leading to faltering growth, it should aid the feeding experience and ensure feeding is effective. The committee are aware of evidence supporting "cue based feeding" in preterm babies, however this population is outside the scope of the guideline and also evidence on the effectiveness of paced bottle feeding vs volume-feeding was not evaluated in this evidence review.
The Breastfeeding Network	Guideline	1	5	Will the guideline allow clinicians to be better informed to help families make the best decisions? The guidelines would benefit from reference to specific services available that could support decisions and enhance care, e.g. National Breastfeeding Helpline, UKDILAS, BfN’s Drugs in Breastmilk service. Is there a plan for a quick reference version of this guideline? Clinicians very rarely have time to effectively consume the original lengthy guidelines.	Thank you for your comment. We hope that the guideline will help clinicians working with families in the postnatal period. We thank you for the suggestions for resources for clinicians. Many of these relate to safe medicine use when breastfeeding and we have added to a recommendation about healthcare professionals having knowledge about the resources around safe medicine use and prescribing for breastfeeding women. We have referred to the British National Formulary which provides useful information for clinicians and prescribers around the safety of medicines when breastfeeding and have acknowledged other specialist sources if further advice is needed. There are no plans to develop any other versions of the guideline, however, the final web version of the guideline is hopefully easier to navigate than the version that was consulted on, as the website allows for easier access to the different sections of the guideline and quick access to the 'Why the

					committee made the recommendations' sections under each set of recommendations.
The Breastfeeding Network	Guideline	1	5	In addition to the recommendations, does the guideline improve or detail how clinicians can access support when needed? Document does make reference to the use of antihypertensives (drugs for lowering blood pressure) and pain relief in breastfeeding mothers but no reference to where HCPs (healthcare professionals) can access further guidance if needed. Signposting to UKDILAS and BfN's Drugs in Breastmilk service could be added	Thank you for your comment. Based on stakeholder feedback we have added recommendations related safe medicine use when breastfeeding. Generally, a useful source for information for those prescribing or advising women would be the British National Formulary (BNF) although we recognise further advice might be needed.
The Breastfeeding Network	Guideline	1	5	How will the guideline transfer to better decision making on the front line? There is a big gap between what women expect to happen in their postnatal care and what they ideally want to happen. Where experience is positive it is because mothers feel heard, are given unhurried evidence-based quality support and positive appraisal from hcp and others in the care of their baby. Where it becomes negative which is all too often it is because mothers feel judged and inadequately supported by hcp under pressure. The language of judgement is often centred around feeding. This guidance seeks to deal with this by reducing the opportunities to support positive conversations on infant feeding and breastfeeding which could negatively impact breastfeeding. The focus primarily on midwives and health visitors being the only source of early day's support lacks evidence	Thank you for your comment. The committee agrees that it is essential that women feel heard and that healthcare professionals respond to their needs and preferences, therefore, we have added a recommendation about this. The recommendations try to emphasise the importance of respectful, sensitive and individualised discussions in general and also in relation to infant feeding. ****Based on the stakeholder feedback, we have also added a recommendation where we specifically say that women should be given information about different support available to them, both statutory and voluntary sector services. And in relation to breastfeeding, the recommendations state that information about opportunities for peer support should be discussed. In general the committee agrees with your comment and we hope that the revisions made will make this more pronounced.

				and certainly risks further exacerbating / worsening breastfeeding drop off rates, acknowledging the valuable additional complimentary support from a peer supporter earlier in the postnatal care journey could service to enhance and drive up the experience of breastfeeding. There is too much emphasis placed on support only from the midwives and health visitors in the early days and no acknowledgement of how valuable other support services could be. This seems particularly relevant to the current Covid pandemic when it appears contact episodes with new mothers are much reduced.	
The Breastfeeding Network	Guideline	1	5	The document doesn't not mention the GP-led postnatal check at 6 weeks which became mandatory in April 2020. If this is being retained then it should also be covered in this guidance.	Thank you for your comment. There is a recommendation about assessing the woman at 6 to 8 weeks postpartum, however, we had not made it clear that this should be by a GP. We have now revised it to clarify.
The Breastfeeding Network	Guideline	1	5	At time of a pandemic there are understandable concerns for those regarded as most vulnerable in our society and this would include babies. It feels fitting to acknowledge important evidence to mothers in the postnatal period about the relatively low risk of transmission from C-19 and to always stress that mother and baby separation should be avoided as up held in international guidance. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30342-4/fulltext	Thank you for your comment. This guideline does not address issues specific to the Covid-19 pandemic, instead we make a reference to guidance that the RCOG has produced.

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The Breastfeeding Network	Guideline	1	35	Does the guideline build awareness of breastfeeding support within the professions and is this an improvement on the status quo? *On page 35 the document makes reference to "evidence of inconsistent information in the postnatal period" and although the draft guidelines talk about the role of HCPs in supporting breastfeeding (and refers to the relevant aspects of this that they should be covering) it doesn't explain how the previously referenced issue with "inconsistent information" will be addressed and improved.*	Thank you for your comment. Continuity of carer, as recommended, would hopefully improve consistency.
The Breastfeeding Network	Guideline	4	13	We are concerned that the recommendation to 'observe at least 1 effective feed' without any mention of support or communication removes any responsibility from hcp to provide effective support within first 12 hours of birth. It implies that both bottle and breastfeeding are equal options.	Thank you for your comment. The section on 'Planning and supporting babies' feeding' covers the issues around support and communication provided in relation to infant feeding regardless of the time period. This section is generally about checks and discussion done to enable and facilitate transfer to community care. Observing an effective feed regardless of the method of feeding is important so that the baby's feeding is off to a good start. We have now defined what is meant by 'effective feed'.
The Breastfeeding Network	Guideline	004 - 005	004 - 006	This feels like the absolute bare minimum standard of care and process heavy.	Thank you for your comment. Based on stakeholder feedback we have revised this section and for example added a recommendation about discussing the postnatal period, what to expect, what support is available and who to contact if there are concerns. We hope these revisions have improved the section.

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The Breastfeeding Network	Guideline	5	1	Discuss and *agree?* Mothers tells us that they might be pushed out of hospital before they are ready, that they might be forced to stay when they wanted to leave, or that the decision to leave would be made jointly by mother and staff. It's important here to add in reassurance that mothers can reply on being able to have a say in this decision.	Thank you for your comment. The recommendations emphasise the need to discuss the timing of transfer to community care with the woman and we have revised the wording of this recommendation to emphasise the importance of woman's preferences. However, there may be different clinical reasons why transfer might not always be possible based on her preferences alone.
The Breastfeeding Network	Guideline	6	001 - 019	Emphasis on support in first 12-14 days is on that provided by the midwife or health visitor. Involvement of these professionals is paramount. However, these roles cover a wide remit and opportunities to support with infant feeding / breastfeeding will be missed without a specific guideline encouraging dedicated support for breastfeeding from a trained peer supporter or lactation consultant.	Thank you for your comment. The committee thinks that generally midwives and health visitors are capable of providing adequate support in infant feeding in most cases, however, the committee agrees that some women and babies may benefit from additional support and we have added this to the recommendations about when there are ongoing concerns with breastfeeding.
The Breastfeeding Network	Guideline	6	7	Mothers (especially first time) value appraisal from their hcp on how well they are doing. They want this affirmation and sometime value this over and above feedback from family and friends. Challenge here is hcp appraisal can often be linked with a baby's growth and appraisal can turn to undermine a mother's confidence if the baby does not gain weight as expected.	Thank you for your comment. We have not made a recommendation about this specifically but we think that through individualised, sensitive and respectful communication, listening to the woman and taking into account of her needs and preferences this can be achieved where appropriate.
The Breastfeeding Network	Guideline	6	007 - 019	Infant feeding should be included in the list of handover points.	Thank you for your comment. We have added this to the recommendation.
The Breastfeeding Network	Guideline	6	19	We know many mothers struggle with infant feeding and have concerns over breastfeeding, this should be expressly	Thank you for your comment. We have added this to the recommendation.

				stated at 19 e.g. concerns that the woman has about her own or her baby's care including infant feeding. By adding this it provides another opportunity to explore concerns, convey support or encouragement. By not covering it at the transfer of care stage you risk missing important opportunities.	
The Breastfeeding Network	Guideline	7	002 - 003	Support available within a mother's network can make all the difference to her experience and ability to adjust to motherhood. Enquiring as to the level of support a mother has in accordance with her wishes could highlight opportunities to discuss alternative ways for a mother to access support – helplines, support groups etc. …	Thank you for your comment. The committee felt that the guideline already addresses the importance of providing information and support, including advice about the way in which these should be provided and the areas they might cover. This recommendation in particular was intended just to highlight that the woman's support network should be involved, in so far as she wishes them to be. In fact, in the final version of the guideline, the recommendation has been changed slightly to say that the woman's partner should be involved, according to her wishes.
The Breastfeeding Network	Guideline	7	004 - 019	C-19 has drastically reduced or removed almost all face to face contact and prioritised what is available to the most vulnerable families. However, every effort could be made to link mothers up with community-based support and reassurance / information given about accessing this safely. This guidance could include promotion of the National Breastfeeding Helpline to mothers before they leave hospital, or within 48 hours of a home birth. See general comment at the start of the breastfeeding intervention section.	Thank you for your comment. We have added a recommendation about giving information before transfer of care to community care or before the departure of the midwife after home birth about what statutory and voluntary support is available.

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The Breastfeeding Network	Guideline	7	11	Women-centred	Thank you for your comment. We agree with the sentiment and we do think that the guideline is woman-centred. However, we have chosen not use this word in this recommendation, instead we are recommending how to communicate with the woman in a way that is woman-centred.
The Breastfeeding Network	Guideline	7	020 - 022	Adding the word 'unhurried' would be good here	Thank you for your comment. We have not added this to the recommendation as we think the issue about providing enough time is already conveyed in the recommendation.
The Breastfeeding Network	Guideline	8	10	Expectations of what to expect in the postnatal period – this should cover information for all settings where postnatal care is offered (hospital, birth centre, home, community). It should include the content, purpose, timing and location of postnatal care, and the roles and responsibilities of all the professionals who may be involved.	Thank you for your comment. We have not given all the detail in the recommendation but The committee agrees that the point about discussing "postnatal period and what to expect" would include the issues you mention. We have also added another recommendation about providing information about what to expect, what support is available and who to contact if there are concerns to the section about 'Transfer to community care'.
The Breastfeeding Network	Guideline	8	14	'healthy lifestyle' yes and include reference to weight management but mothers want greater emphasis and enquiry from hcps on their own physical recovery.	Thank you for your comment. The recommendation starts by asking the woman about her general health and whether she has any concerns, the recommendation also includes discussing any symptoms or signs related to physical problems so we think this point is covered already.
The Breastfeeding Network	Guideline	16	3	It is a positive that co-sleeping appears as a potential option. However, location of where the baby sleeps i.e. in the same room for first 6 months is missing, supporting parent and baby to stay close allows for opportunities for night care to be offered and for the baby to	Thank you for your comment. We did not review evidence on safer sleeping practices in general (apart from bed sharing/co-sleeping) but are aware of established guidance and have added this to a recommendation about providing information

				be more regularly monitored. Reference to up to 2 units of alcohol should be checked.	to parents about caring for their baby. In the rationale and impact section we provide some examples of sources for this guidance. The 2 units of alcohol came from the evidence reviewed in relation to risk factors for co-sleeping, see evidence review N.
The Breastfeeding Network	Guideline	17	15	Promoting emotional attachment – good to see this reference. This section and the related definitions could be better aligned with evidence such as Unicef Baby Friendly Recommendations with resources for families and professionals. Other approaches could also be considered such as Suzanne Zeedyk powerfully speaks of 'babies born ready to build relationships' and how our behaviour in caring and feeding routines with primary carers is paramount to ensure infant security. Less well evidenced is the prevalence of 'products' made available to try and convey this attachment and how these can be avoided as they are neither evidence-based any may fetter connection.	Thank you for your comment. We have revised the definition of emotional attachment in the Terms used in this guideline. The UNICEF BFI guidelines have not been accredited by NICE so we have not made a reference to them in the recommendations. However, we think that our recommendations do not contradict their guidance and overall they align well. Based on the information you have provided, it seems that the general idea of parents caring behaviour influencing infant security and attachment has also been captured in our guideline.
The Breastfeeding Network	Guideline	17	21	Traumatic birth experience should be added to this list of bullets, the experience of birth is well documented as being a factor that can create additional challenges in bonding	Thank you for your comment. We have added experience of a traumatic birth to the list.
The Breastfeeding Network	Guideline	20	10	Reference to UNICEF Baby Friendly standards to support conversations around feeding	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.

The Breastfeeding Network	Guideline	21	008 - 009	This could be explained better so as to not undermine quality of breastmilk. Need to say whether this is from birth, and a reminder that this is a continuation of the antenatal recommendation. And if this is similar to the general population recommendation why are women who are feeding their babies with infant formula missed out. There could be more inclusive words found while emphasising the particular need for breastfeeding. As well as supplementation other Vitamin-D boosting behaviours should be discussed.	Thank you for your comment. The issue of vitamin D supplementation is not covered by this guideline. However the NICE guideline on vitamin D includes a section about raising awareness among healthcare professionals.
The Breastfeeding Network	Guideline	22	16	In the context of C-19 it is important to note that face to face support will be limited. All forms of support should be offered to ensure a mother has a complete knowledge of what she can access.	Thank you for your comment. Despite and beyond covid-19 pandemic, we recommend that face to face breastfeeding support is offered and supplemented by other forms, such as written, digital or telephone support as needed/appropriate.
The Breastfeeding Network	Guideline	23	1	Information about opportunities for peer support should be highlighted earlier in the guidance within first 48 hours to compliment the midwife / hcp role.	Thank you for your comment. We have added a recommendation about providing information before transfer of care from the maternity unit to community care or before the midwife leaves after homebirth about available support, both statutory and voluntary and who to contact if concerns arise.
The Breastfeeding Network	Guideline	23	General	Does the guideline go far enough, if not, what should or could have been included? Page 23 talks about increased breastfeeding support and encouragement to young women or those from low income or disadvantaged background but no reference to the BAME community? I couldn't see any reference to info/support around	Thank you for your comment. The evidence we reviewed did not identify women from BAME backgrounds to necessarily need additional breastfeeding support. However, the committee are aware of the disproportionate adverse outcomes among BAME women and babies and those living in deprived areas as reported by the

				expressing/breast pumps which I wondered if this might be relevant particularly in the case of premature babies where establishing breastfeeding can take longer (this was mentioned in the previous guidelines) No mention of 6-8 week postnatal GP review Peer support could be mentioned much earlier in the document I would have thought traumatic birth experience should have been included in the list on page 17 1.3.17 regarding mothers who may need additional support in bonding/emotional attachment	MBRRACE-UK reports on maternal and perinatal mortality. We have therefore, added a recommendation addressing this issue so that healthcare professionals would be aware of these disparities. The 6-8 week postnatal examination by a GP is in the guideline. We had not specified in the consultation version which healthcare professional should perform this. We have now revised this to specifically say GP. We have also now added a recommendation that before transfer of care to community care or before the midwife leaves after a homebirth, that information is provided about available support, including voluntary services. We have also added a specific mention about potential referral to peer support if there are ongoing concerns with breastfeeding. We have also added experience of traumatic birth to the list of parents who might need additional support with bonding/emotional attachment.
The Breastfeeding Network	Guideline	24	018 - 019	Other actions, such as demonstrating techniques to improve positioning and attachment [a reminder the health professional is explaining and teaching, not taking control away from the mother]. If difficulties persist the practitioner should give suggestions to enable the mother to have an appropriate feeding plan based on the hospital guidelines, or refer to the local Infant Feeding Lead, or breastfeeding group.	Thank you for this suggestion, with which the committee agreed. In the final version of the guideline this recommendation now states that other actions could include referring to additional support such as a lactation consultant or peer support.
The Breastfeeding Network	Guideline	General	General	Are the recommendations made within the guideline deliverable with current resources available to clinicians and communities? I'm	Thank you for your comment. We are also aware that there have been less face to face contacts postnatally. Despite and beyond the

				not convinced that all the recommendations are deliverable with the current resources, especially during this pandemic. My understanding is that in many places face to face assessments are drastically reduced. I think in principal the idea of observed feeds in the first 24 hours after birth within the first week is a step in the right direction. But 24 hours is a long time for the family to experience feeding difficulties unsupported if feeding is not well established. Also what training will this observer have to ensure they can correctly assess whether feed is effective or not. Simply rolling out the existing workforce without enhanced training and support will diminish the intended effects of the recommendations within the guideline.	pandemic, this guideline recommends face to face contacts and while remote contacts might have advantages and benefits, they should not completely replace face to face contacts. We recommend that before transfer from the maternity unit to community care or before the midwife leaves after a homebirth, at least one effective feed would be observed, therefore, in many cases this happens before 24 hours after birth. Feeding is then assessed, discussed and possibly observed at every contact. We have added a simple definition of "effective feed" in the guideline. Training and staff competencies are outside the remit of this guideline, however, we would assume that midwives at the maternity units and doing postnatal home visits and health visitors would have the skills to observe and assess feeding appropriately.
The Institute of Health Visiting	Evidence Review D	9	13	At the moment the PHE commissioning guidance states that the HV new birth contact should be completed “within 14 days” of the birth – with a generally accepted KPI that it is within 10-14 days. We would agree with the rationale for introducing a greater degree of flexibility to personalise support based on individual need, although this should be driven by the needs of the family, rather than the organisation and the expectation should remain that, for most families, this should be delivered ideally within 10-14 days of the birth. The proposed blanket recommendation to delay the start of the HV postnatal support for all women removes this level of personalisation, rather	Thank you for your comment. The committee strongly agree with you about the importance of the health visitor 'offer' and the relationship they establish with the woman and family. They also understand that the role of health visitor and midwife is markedly different and they discussed that with the visits arranged as they currently are, the two roles can become blurred, overlapping and confused from the perspective of the woman and the family. The committee therefore recommended the first postnatal health visitor visit take place between 7 and 10 days after transfer from midwifery and although they have since discussed your comment at length they decided this should

				than enhances it. The role of the health visitor is very different to the role of the midwife and the proposed recommendation would in effect delay the start of the HV postnatal “offer”. The early postnatal period represents a time of considerable adjustment for many parents and the HV service provides crucial support with transition to parenthood, early identification of risk factors and most importantly the establishment of the HV/ parent relationship through continuity of carer. There is much to be gained by having the HV involved in this early period. Delaying the start of the HV postnatal support “offer” has the potential for unintended consequences in terms of eliciting health needs and negative impact on the development of a trusting relationship. There is significant evidence that women will disclose needs more readily in the context of an established relationship i.e. this period lays the foundation for this important quality and safety component of future care which lasts until the child is 5. It is so much more than an “end” of midwifery care. Having the HV as part of their early journey, through the ups and downs lays the foundation of this relationship. The Guidance could usefully recommend that commissioners support “reporting by exception a ‘preferred time’ up to 21 days to accommodate the baby’s or parents’ needs or circumstances” for example when the baby spends extended time in NICU. The needs or circumstances of the baby and the parent(s) should each be	remain in the final guideline. They believe that if the health visitor's antenatal care visit has taken place and there has been a good transfer between midwife and health visitor, including the midwife telling the family who they can contact in the days before the first postnatal health visitor visit then the gap will not be problematic. The committee agree that any perceived problems associated with this gap would also be mitigated by the provision of all relevant information by the midwife to the woman and family, which is also recommended in the guideline.

				considered in their own right, bearing in mind the criticality of safeguarding rightly highlighted by the Committee. Governance and accountability: There should be no gaps in the postnatal journey where no service is accountable for the care. Conversely, having a period of overlap, when both the HV and MW services are working with a family also provides additional support and reduces the risk of families falling in the "gap" between services – who will be picking up changes during the 7-14 day period between the end of midwifery care and the start of HV? For some families, with pre-existing needs, the HV may have been working with them on these issues throughout pregnancy and this revised guidance will in effect delay the re-commencement of this work postnatally. In response to the Committee's concern about the lack of support between 2 weeks and 6 weeks: the recommendation to address this would be better achieved by increasing the emphasis on the HV role beyond the "mandated" contacts (the mandated contacts are only a small part of what a health visitor does in the postnatal period). The HV should tailor support to individual need – PHE describe this as "universal in reach, proportionate in response", by offering additional postnatal contacts in response to those that need them, for example, for a breastfeeding or perinatal mental health problem identified at the first HV postnatal contact or previously identified need. The Committee's caveat that, "If, however, there	

				were concerns about the woman or the baby, this would have either already been identified from the antenatal visit or would be passed on from the midwifery team to the health visitor team" is not supported by the evidence. The evidence is clear that needs change over time and in particular between the pre and post birth circumstances of families – the HV holistic assessment is a "process assessment over time", rather than a single snapshot, which takes account of changes in families' circumstances. The accuracy of these assessments is dependent on the establishment of a trusting relationship between the parent and the HV. Engaging with families early in their parenting journey enables this relationship to develop which will then continue into the first years of a child's life – this is central to the effectiveness of the HV service (It is so much more than the delivery of a series of "tasks").	
The Institute of Health Visiting	Evidence Review D	10	23	The Committee's recommendation that an additional postnatal contact could be offered by the HV is already an option within the existing national HV service specification – described as the "universal plus" offer by Public Health England. We therefore suggest that the emphasis should be on the importance of providing a level of postnatal support that is proportionate to need, with additional postnatal HV contacts in addition to the universal contacts, where this is indicated to address identified need and to provide an enhanced level of support.	Thank you for your comment. The committee did discuss that a comprehensive routine antenatal home visit is mandated by the Healthy Child Programme but they were also aware that these do not always routinely take place or they take place in some trusts and not in others. Where an antenatal home visit has not taken place then the committee agreed the length of time until the first postnatal visit might be too long and therefore an additional earlier postnatal visit could be arranged even for a low risk 'universal' family.

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The Institute of Health Visiting	Evidence Review D	10	32	In line with the comments above – we agree that the current KPI of New Birth Visit within14 days is too restrictive for some families – the expectation should remain that, for most families, this should be delivered ideally within 10-14 days of the birth. However, we would suggest increasing the eligibility period to 7 to 21 days to allow providers to "report by exception", in order to accommodate the baby's or parents' needs or circumstances.	Thank you for your comment. The committee agree that the recommendation allows for greater flexibility with the first health visitor home visit proposed between 17 and 28 days after the birth (knowing that discharge from midwifery care usually happens 10 to 14 days after birth).
The Institute of Health Visiting	General	General	General	The term 'postnatal' is understood in different ways. This NICE guideline could benefit from stating the postnatal period it covers in the introduction. For example, is this postnatal period, birth to 6 weeks? to 12 weeks? (could they be ambitious and have this guideline as birth to 1 year and provide further evidence and quality standards to strengthen quality of care for woman and babies)	Thank you for your comment. This guideline covers the first 8 weeks after birth although postnatal period of course is not limited to that. We have stated this in the Context section of the guideline.
The Institute of Health Visiting	Guideline	4	3	1.1 Organisation and delivery of postnatal care This recommendation starts with time of transfer to home care and then the recommendations before transfer from the maternity unit to home care. There are no recommendations regarding the quality of care on the postnatal ward. We know from surveys of woman conducted by NCT that woman report a lack of kindness in the care they receive, particularly in the hospital postnatal ward. While it is known that these areas are commonly understaffed and it is suggested that the long history of postnatal care being perceived as least important, in	Thank you for your comment. The guideline does cover elements of the care in the postnatal ward, for example the section on Principles of care (formerly called 'Communication with women') would be applicable to all postnatal care regardless of location. We have changed the order of the sections so that the Principles of care is the first section of the guideline. The order in the draft version of the guideline might have inadvertently given the impression that the guideline only starts from the point of transfer from the place of birth to community care so hopefully by changing the order of the

				comparison with antenatal and labour care, gives this area a low value, leading to reduced commitment to high-quality care. This NICE guideline could contribute to strengthening the quality of care in maternity units through setting evidence- based standards for this period prior to transfer to home care. The first 24-48 hours post-birth is an extremely important phase for new mothers: although some women remain in hospital at this time, individualised care may be lacking and women report little emotional support while they struggle with their own recovery and care for their newborn. There must be a focus on improving postnatal ward experience through co-design, based on women's views, and promoted through the MVP. Length of hospital stay should be appropriate for individual mother and baby and therefore have a flexible offer available.	sections improves this. However, the scope of the guideline did not include any specific review questions in relation to the quality of care in the postnatal ward as such. The committee agrees that the first 24-48 hours after birth are very important. The recommendations in the 'Principles of care' section emphasise that communication and information provision should be individualised, sensitive, supportive and respectful. The guideline also recommends that the emotional and psychological wellbeing is assessed at every postnatal contact (this would include the postnatal ward). The committee agrees that the length of stay should be depended on individual factors and that has been captured in the recommendations.
The Institute of Health Visiting	Guideline	5	001 - 002	Add, Provide information about what practical and emotional support the mother and her partner / family can expect on discharge from the midwife and other professionals / services including health visitor and GP over subsequent weeks.	Thank you for your comment. We have added a recommendation about providing information about what to expect during the postnatal period, what support is available and who to contact if there are concerns before transfer to community care or before the departure of the midwife after home birth.
The Institute of Health Visiting	Guideline	5	007 - 021	Recommendation 1.1.3 The committee agreed that the first postnatal visit by the midwifery team should be by a midwife (and not, for example, by a maternity support worker), face-to-face and, depending on the woman's circumstances and preferences, in the home. There is evidence on the benefits of continuity of carer from antenatal to	Thank you for your comment. The committee agrees with the comment and recommend providing continuity of carer in the guideline (see section on supporting women to breastfeed, which covers both the antenatal and postnatal periods).

				postnatal. Early identification of mental health disorder would be expedited if the woman saw a midwife who knew her and could detect unusual mood or behaviour. Knowledge of a woman's preferences and values about, e.g. infant feeding, as well as the influences from family and community, could also help a caregiver direct support in the most effective way.	
The Institute of Health Visiting	Guideline	6	002 - 004	First health visitor visit 1.1.4 We would recommend that the standard states that 'this first postnatal visit by the health visiting service should be by a health visitor, face to face in the woman's home unless there are exceptional risks to doing so'. The guidance states, "Consider arranging the first postnatal health visitor home visit to take place between 7 and 14 days after transfer of care from midwifery care so that the timing of postnatal contacts is evenly spread out"- this may be interpreted in different ways and delays the start of the HV role in the postnatal period, (which is very different to the midwifery role) with potential for negative unintended consequences. See detailed comments in Postnatal care [D]	Thank you for your comment. The recommendation already states this is a home visit so we have not made the change suggested (of course there may be exceptions when this is not possible). There should be no delay in the transfer of care to health visitors, but to ensure that the handover is smooth, we have added a recommendation about ensuring that the transfer of care between midwifery and health visitors are clearly communicated between the healthcare professionals and the to the woman/family. The reason for the timeframe suggested in this recommendation is to spread the visits during the first 8 weeks more evenly so that the family is not left without a visit by a healthcare professional for many weeks during the first weeks after birth.
The Institute of Health Visiting	Guideline	6	008 - 019	1.1.6 Communication between healthcare professionals at transfer of care There are good examples of communication pathways between midwifery, HV and GP developing in the maternity transformation early adopter sites. Information on the baby's father/significant partner should also be	Thank you for your comment. We have added to the recommendation that information about who holds parental responsibility for the baby and the woman's next of kin should be shared between healthcare professionals.

				communicated between healthcare professionals.	
The Institute of Health Visiting	Guideline	7	14	Amend: to add *independent of the family i.e.* translated by an interpreter *independent of the family* to overcome language barriers	Thank you for your comment. We have revised this to say "appropriate translator" as suggested by another stakeholder.
The Institute of Health Visiting	Guideline	7	23	Add in women whose babies are being removed under child protection proceedings	Thank you for your comment. This recommendation is a reference to the NICE guideline on pregnancy and complex social factors which covers the groups listed in the recommendation. The group mentioned in your comment may well also be relevant, however, this is not covered by the above NICE guideline.
The Institute of Health Visiting	Guideline	8	17	Physical activity please can this reference the CMO guidance on PA postnatally.	Thank you for your comment. A reference to the CMO physical activity guidelines has been added.
The Institute of Health Visiting	Guideline	10	6	Add as per italics: At each postnatal contact, give the woman the opportunity to talk about her birth experience, and provide information about relevant practical and emotional support services, if appropriate.	Thank you for your comment. The committee discussed your suggestion and agreed to edit the recommendation to say that the woman should be given information about relevant support and birth reflection services, if appropriate. In addition they cross referenced from this recommendation to the NICE guideline on antenatal and postnatal mental health, specifically the section on traumatic birth, stillbirth and miscarriage and the NICE guideline on post-traumatic stress disorder.
The Institute of Health Visiting	Guideline	10	9	Amend as per italics: All healthcare professionals should ensure appropriate referral if there are concerns about the woman's mental or physical health and wellbeing.	Thank you for your comment. The committee considered your suggestion and agreed that 'health' is being used in its broadest sense, in line with the WHO definition to mean health and wellbeing. They therefore did not make any changes to this recommendation

					but they did cross refer to the NICE guideline on antenatal and postnatal mental health in a number of key places in the guideline.
The Institute of Health Visiting	Guideline	14	1	It states “Assessment and care of the baby Carry out a complete examination of the baby at 72 hours and 6-8 weeks” It needs to make it clear who is expected to do this NIPE i.e. midwifes / GP/ health visitors, or at least to specify the training? Greater clarity is specifically also needed for growth monitoring as this is not clearly specified in the current national health visiting service specification; although some guidance is provided by RCPCH, it remains “guidance” and has led to Serious Incidences and poor outcomes for affected infants who have fallen in the gaps between services, At the 6-8 week HV checks this will need to be agreed as there is wide variation in current HV practice on examination of babies at both the 10-14 day review and 6-8 week review. This would potentially be a change in practice for some and would need training and guidance for health visitors	Thank you for your comment. Who performs the complete examination of the baby depends on the local arrangements and we have not commented on this. However, we have added a recommendation that midwifery services need to ensure that the transfer of care to health visitors is clearly communicated to the health visitors and to the woman/family. This should enable smooth care continuation.
The Institute of Health Visiting	Guideline	15	21	Baby Check is new to many this would require training and guidance for practitioners.	Thank you for your comment. Baby Check is a simple tool to use so we do not expect it requires extensive training although we recognise it may not be widely known or used by healthcare professionals in current practice.
The Institute of Health Visiting	Guideline	16	6	*Not using pillows or duvets for the baby* – it needs to be clear that this also relates to co-sleeping	Thank you for your comment. The recommendation stem states that this related to "safer practices for bed sharing".

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The Institute of Health Visiting	Guideline	16	10	'have had 2 or more units of alcohol'. This assumes knowledge of units, how much consumed and acting on this. Safer to state, 'have consumed any alcohol'. This is also more consistent with the other cautions in lines 11, 12, 13.	Thank you for your comment. The 2 units of alcohol is based on the evidence reviewed (see evidence review N), therefore, we cannot assume that any alcohol use is harmful.
The Institute of Health Visiting	Guideline	17	1	Promoting emotional attachment 1.3.15 This should recommend promoting sensitive attuned relationships through provision of information, role modelling and, if appropriate, skills training. The guideline should consider evidence that supports the value of professionals using informal or structured observational skills such as the Newborn Behavioural Observation (NBO) to undertake assessment and to support parent-infant relationships that are sensitively attuned to baby states and behaviours. The guideline should identify the interdependence of infant mental health and perinatal maternal and paternal mental health. Reference to evidence-based interventions available to professionals that support improved parent infant relationships and quality of interactions. It would be useful to recommend the updated NICE guidelines applicable here: NICE PH 40 states- The trained nurse should visit families in need of additional support a set number of times over a sustained period of time (sufficient to establish trust and help make positive changes). Activities during each visit should be based on a set curriculum which aims to achieve specified goals in relation to: maternal sensitivity (how sensitive the	Thank you for your suggestion, which the committee discussed. They did not feel they could cross refer to the NICE guideline on social and emotional wellbeing in the early years because the population for that guideline is specifically vulnerable children, which would be outside the scope of this guideline. They did agree to cross refer to the NICE guideline on antenatal and postnatal mental health albeit in a different recommendation about providing the woman with the opportunity to discuss her birth experience. This is in recognition of the broader impact this could have and the support that may be needed to mitigate longer lasting effects.

				mother is to her child's needs) the mother–child relationship home learning (including speech, language and communication skills) parenting skills and practice NICE cg 192, 2014 specifies that practitioners should recognise that some mothers might experience difficulties with the mother-baby relationship and requires that health professionals should assess the nature of this relationship at every postnatal contact (Nice 2014a, recommendation 1.9.12). It is expected that suitably qualified health professionals should be available to discuss any concerns the mother may have and consider further interventions to improve the mother-baby relationship if needed (NICE 2014a, recommendation 1.9.13).	
The Institute of Health Visiting	Guideline	20	3	'Managing babies' feeding' – 'supporting babies' feeding' more appropriate, as for line 12.	Thank you for your suggestion, in light of which the committee agreed to change the wording of the title, which now reads 'Planning and supporting babies' feeding'.
The Institute of Health Visiting	Guideline	22	022 - 024	Access to help for perinatal distress is usually through primary care services, such as the GP, midwife, or health visitor, and is provided free at the point of delivery UK guidance suggests that women should be screened on first contact with health services to identify those who may need further assessment. The NICE guideline states that most women with additional mental health needs will be identified and treated in primary care (NCCMH 2014). As the greatest number of new episodes of postnatal depression occur 2-3 months after birth (Gavin et al 2015, O'Hara and McCabe	Thank you for your comment. The review questions in this guideline focused on the first 8 weeks after birth. This is of course not the end of the postnatal period but it was agreed during the scoping phase for this guideline to focus on the most critical first weeks after birth. This is stated in the context section of the guideline. Postnatal mental health is generally covered by the NICE guideline on antenatal and postnatal mental health which you reference. However, the postnatal care guideline states that between 6 to 8 weeks after birth, a GP should assess the woman's health (both physical and

				2013) the burden of this responsibility inevitably falls on health visitors as they are the only primary care health professionals who routinely see all mothers and babies beyond the first 6 weeks of a baby's life. Mothers sometimes find it difficult to disclose how they are feeling during pregnancy and the year after delivery. There are many reasons for this including stigma, lack of information about perinatal mood disorders and the nature of the relationships between mothers and health professionals (Dennis and Chung-Lee 2006). It is therefore important to specify the duration of the postnatal care to which this guideline applies and to make clear further guidance applicable beyond this duration.	mental health). We had previously not clarified who the healthcare professional doing this should be, however, based on stakeholder feedback and the latest GP contract between NHS England and the BMA, this has now been clarified to be by the GP meaning that for many women a GP will see them after the first 6 weeks.
The Lullaby Trust	Evidence Review L	9	20	The following comments are given via Professor Colin Morley, who was one of the original researchers and remains linked to us to give advice on the Baby Check process: In the Draft guidelines they have just focussed on what signs and symptoms (alone or in combination) in babies are associated with serious illness or mortality. They have included one review, "Symptoms and signs in infants younger than 6 months of age correlated with the severity of their illness. C. J. Morley, A. J. Thornton, T. J. Cole, M. A. Fowler and P.H. Hewson Pediatrics 1991;88;1119-1124". They have excluded other papers because they did not meet protocol eligibility criteria. The above paper reported all the signs and symptoms found in the 1007 babies categorising them by the	Thank you for your comment. Analyses were conducted in babies defined as having "serious illness" vs "well", as comparing the most extreme pair would yield the most meaningful result i.e. strongest association between individual symptoms and signs with serious illness. We agree it would be interesting to conduct different analyses across all health states, however these analyses are likely to show a weaker association between individual signs and symptoms with serious illness and would not influence recommendations . ****The evidence was graded as very low quality based on the quality assessment using GRADE (full details seen in appendix F in the evidence review), which takes into account risk of bias, inconsistency,

				severity of their illness. However, in the L1 appendix they only summarised the data for serious illness vs. well and then set out the "Clinical evidence statements for signs". They said there was very low quality evidence showing a clinically important increase in the following signs in babies who were seriously ill compared to well babies. It is not clear why they are graded very low quality evidence. They list the following signs and I have shown how commonly they occurred in seriously ill and well babies. intermittent or persistent cry during examination. 62% in serious, 24% in well weak or whimpering cry. 23% in serious, 0% in well high pitches or moaning cry. 23% in serious, 0% in wellmoderate or severe rash. 12% in serious, 3% in well mild hypotonia. 36% in serious, 3% in well* peripheral cyanosis. 15% in serious, 2% in well hyperinflation of the chest. 19% in serious 2% in well audible expiratory grunt 7% in serious, 0 % in well distended and tense abdomen 6% in serious, 0% in well tender abdomen 17 % in serious, 0% in well transient loss of awareness or no awareness of surroundings. 33% in serious, 0% in well rectal temperature	indirectness, and imprecision. ****The committee agreed that there were gaps in the evidence about signs and symptoms for serious illness. This may have been partially due to the restriction in outcomes set out in the review protocol to ensure that this guideline doesn't overlap with other disease specific NICE guidelines. We agree that using individual signs and symptoms has disadvantages, the aim of the review was to identify evidence looking at signs and symptoms alone or in combination, however we didn't find any evidence on signs and symptoms in combination that met our inclusion criteria for this review. Nonetheless, evidence review L2 does cover signs and symptoms in combination through its examination of scoring systems.

				>38.2 C. 29% in serious, 0% in well crepitations (on auscultation). 13% in serious, 0% in well reduced hydration. 12 % in serious, 0% in well central cyanosis 5 % in serious, 0% in well partially or completely extended posture. Partially; 25% in serious 0% in well. Completely; 2% in serious, 0% in well it is not clear why they chose these 16 signs out of the 39 signs reported in the above paper. They say, "The committee arrived at the listed signs and symptoms by using the signs and symptoms from the NICE guideline on fever in under 5s (CG160) as a basis and then the list was reviewed against the signs and symptoms from the NICE guideline on sepsis (NG51) and neonatal infection (early onset) (CG149) to check for omissions." The problem with that approach is that the correlation and predictive value of those signs individually with the severity of a baby's illness has not been reported. I make this point because in the above study every possible sign or symptoms that could be assessed was analysed and presented as a proportion in the four categories of illness: well, mildly ill, moderately ill and seriously ill. The evidence for the guideline also refers to the traffic light system which as far as I can see does not appear to be evidence based and does not include important signs such as floppiness, lack of alertness or drowsiness	

				although they are mentioned in the NICE Guideline in Fever under 5. A problem with using individual signs to suggest serious illness is that many occur in mildly, moderately, or seriously ill babies and so although they may have some discriminating power to differentiate from well they cannot be used to indicate serious illness. For symptoms, reported by the mother both in hospital and at home, they said there was very low-quality evidence for clinically important increase in babies who were seriously ill compared to well babies. It is not clear why they chose just 14 symptoms out of 28 recorded in the study: increased irritability. 78% in serious, 8% in well not himself/herself. 79 % in serious, 5% in well abnormal cry. 69% in serious, 4% in well not feeding normally. 71% in serious, 5% in well noisy breathing. 43 % in serious, 5% in well feels hot. 53 % in serious, 5% in well vomiting (not posseting). 41% in serious, 3% in well bile-stained vomiting. 3% in serious, 0% in well diarrhoea. 27% in serious, 3% in well cold hands and feet. 39% in serious, 3% in well	

				pallor. 56% in serious, 3% in well approximately half normal intake of fluids. This was not reported in the above study less than 1/3 normal intake of fluids. 19% in serious, 0% in well convulsions. 4% in serious, 0% in well As with the signs, many symptoms occur in mildly, moderately, or seriously ill babies and so although they may have some discriminating power to differentiate well from serious they cannot be used individually as indicators of serious illness. Concentrating on the predictive value of individual signs and symptoms for serious illness misses the fact that many occur in babies who are not seriously ill. Also, it is better to use a combination of signs and symptoms, just as any clinician would do. This is much more useful and predictive.	
The Lullaby Trust	Evidence Review L2	17	19	The following comments are given via Professor Colin Morley, who was one of the original researchers and remains linked to us to give advice on the Baby Check process: This focusses on scoring systems for identifying or predicting illness severity in babies. It includes four papers all used the Baby Check Scoring system because this was considered to be the only scoring system for assessing the severity of illness. However, there are other papers about Baby Check that do not seem to have been considered and assessed. They were: 1. Baby Check and the Avon infant mortality	Thank you for your comment. The list of references provided do not meet the inclusion criteria for the review. References 1,2,3, and 7 were captured in our search and reasons for exclusion are listed in Appendix K of the evidence review. References 5 and 8 were not captured in our search but even if they were they would have been excluded as they were not conducted in OECD high income countries as set in our protocol. References 4,6, and 9 were not captured in our search, but even if they were they would have been excluded as there were no model performance or predictive accuracy

				study. Arch Dis Child 1991; 66(9):1077-1078 2. Field trials of the Baby Check score card in general practice. Arch Dis Child 1991; 66(1):111-114. 3. Field trials of the Baby Check score card: mothers scoring their babies at home. Arch Dis Child 1991;66(1):106-110. 4. Health care professionals' recognition of illness in infants: a New Zealand pilot study of Baby Check. Nursing Praxis in New Zealand 1994; 9(2):16-24. 5. Use of Baby Check to assess the severity of illness in babies attending a clinic in The Gambia. Journal of Tropical Pediatrics 1994; 40(3):144-148. 6. Parents' recognition of illness in infants: a New Zealand pilot study of Baby Check. Nursing Praxis in New Zealand 1994; 9(1):24-35. 7. Evaluation of the baby check score in emergency room. Acta Paediatrica Sinica 1995; 36(3):187-191. 8. Baby check in India: assessing the severity of illness in babies in a Calcutta out-patient clinic. Journal of Tropical Pediatrics 1995; 41(3):158-163. 9. Acceptability of Baby Check to an underprivileged population. Maternal and Child Health 1996; January:20-24. There are clinical evidence statements for those babies who were assessed in hospital investigating the accuracy of different score cut-offs to identify babies with possible serious illness requiring hospital treatment. The guideline assessment of these has used a very statistical approach. However, clinically there are a number of other things that need to be considered when	outcomes as set out in our protocol. We agree that there are various variables that determine whether a baby is to be admitted to hospital for observation, however the model performance outcomes and predictive accuracy outcomes for scoring systems assessing serious illness were set as an a priori in the protocol and not based solely on the Baby Check scoring system. ****In the field trials of Baby Check in hospital, we recognise that senior house officers, registrars, and consultants all assessed the severity of each baby's illness. However, the consultant's assessment of illness severity was selected as the reference standard for the evidence review, which was considered to be both the most qualified and comprehensive assessment in line with the protocol.

				assessing such a system. Baby Check aims to assess the severity of most acute Illnesses in infants, which are very variable, with many different conditions and are at different stages of illness development when they are seen. Assessing what is a serious illness, or not, is not binary and depends on the condition, its stage, and any treatment and management they receive. Admission to hospital is very subjective depending on the day of the week, the experience of the doctor, the availability of beds and the competence and social circumstances of the mother. The medical staff have to make sure the child is safe and so babies will be admitted to hospital for observation because it may not be obvious whether they will deteriorate or not. For these reasons the techniques used to assess the accuracy of the scoring does not do it justice An important question is how does the scoring system compares with clinical judgement when used by doctors or parents? In the field trials of the Baby Check in hospital the duty senior house officer or registrar and two consultants independently graded the severity of each baby's illness without knowledge of the Baby Check score. They assessed the babies' presentation and consultants reviewed the notes using the same scale and without knowledge of the score. The illness grades took account of investigation results, diagnosis, treatment, and outcome. The consultants and registrars agreed about the need for hospital	

				administration only about 75% of the time. The score's sensitivity and predictive values were similar to those of the registrars grading. The scores specificity was 87%. Babies with serious diagnoses scored high, and with minor illnesses scored low. The babies had a broad range of diagnoses, from minor complaints, such as nappy rash, to serious illnesses such as meningitis. The predictive value for requiring hospital admission increase with the score rising to 100% for scores of 20 or more. As an indication of the conditions that were assessed the table below shows the diagnoses, number of babies and the median and range of the Baby Check scores. The range of scores is an indication that each diagnosis may present as either mildly ill or severe.	
The Lullaby Trust	Guideline	15	16	This note about safe sleeping only refers to more information on bedsharing. This should be expanded – see below for more details.	Thank you for your comment. We did not review evidence on safer sleeping practices in general (apart from bed sharing/co-sleeping) but are aware of established guidance and have amended the recommendation to state this. In the rationale and impact section we provide some examples of sources for this guidance.
The Lullaby Trust	Guideline	16	9	There is evidence that this should include a warning against co-sleeping if baby was born prematurely or low birthweight. This was included in the 2014 guidance and is strongly backed in the studies listed. It does not appear to be an area that was considered in the review. We therefore see it as vital that this bullet point is included: Inform parents	Thank you for your comment. The committee felt that the issues of parental alcohol consumption and drug use were already covered by the recommendation about co-sleeping but they did agree that the issue of low birthweight was missing, so they amended the recommendation accordingly. They were unable to mention pre term

				and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS may be greater with: parental or carer recent alcohol consumption, or parental or carer drug use, or low birth weight or premature infants. [new 2014] It should also be reiterated here and throughout the guidance that there is a significant difference between not advising against bed-sharing and actively encouraging it. Whilst we welcome active and open conversations with families that are not a blanket ban of bedsharing, any discussion of the high risks situations when bed sharing should not take place needs to recognise that these can and do change on any given night. A family should not therefore be listed as 'low risk' overall – any family can become high risk very easily. There are also some families for which bedsharing should be actively discouraged due to the continued risk that cannot be mitigated against.	babies as this population is outside the scope of the guideline, this has now been explained the rationale and impact section. However they agreed that by including 'low birthweight' then pre term babies are covered by implication as they will always have a low birthweight. Finally, the committee felt it would help to clarify the point by defining 'low birthweight' in the 'Terms used in this guideline' section, which they have done.
The Lullaby Trust	Guideline	16	13	There is evidence around other safer sleeping advice which should also be referenced here – e.g. baby should sleep on their back, be kept smoke free. The draft scope states that "The postnatal period presents opportunities to identify needs and implement effective care to reduce maternal and infant morbidity and mortality." Sudden infant death is one of the leading causes of postneonatal mortality1 which can and should be addressed in the postnatal period, when infant care routines are becoming established. The co-sleeping	Thank you for your comment. We did not review evidence on safer sleeping practices in general (apart from bed sharing/co-sleeping) but are aware of established guidance and have added this to a recommendation about providing information to parents about caring for their baby. In the rationale and impact section we provide some examples of sources for this guidance, for example UNICEF, Basis and the Lullaby Trust. We have also added to the same recommendation about the importance of maintaining a smoke-free environment for

				recommendations within the guidance are currently the only mention of SIDS and what parents might be able to do to reduce the risk. However there are many other modifiable risk factors, and it cannot be taken for granted that reliable, evidence-based information about them will reach parents or that safer sleep practices have become standard. The Office of National Statistics mentioned safer sleep campaigns as a possible reason for low SIDS rates,2 which healthcare professionals must be part of to be successful.3 The consequences of unsafe sleep are too great not to be acknowledged by the healthcare professionals who are best-placed and best-qualified to hold this discussion with parents. Safeguarding these recommendations within NICE guidance will ensure that all parents receive this life-saving information. To be most effective, discussion about safer sleep should take into account parents' individual beliefs and motivations for decisions about infant care.4 In addition to co-sleeping, the other modifiable risk factors that should be covered within the postnatal contact include sleep position; the use of a firm and flat mattress and minimal bedding; avoidance of overheating and head-covering; the use of a dummy; how to spot signs of illness; and especially, smoking.5,6 Smoking during pregnancy accounts for 30–40% of SIDS cases7 and research has also highlighted smoking in the postnatal period as a significant risk factor.8 We are aware	the baby and made a reference to the NICE guideline on smoking: stopping in pregnancy and after childbirth.

				that Guideline PH26 'Smoking: stopping in pregnancy and after childbirth' covers smoking cessation in the postnatal period, but the importance of quitting smoking for maternal and infant health cannot be understated, and we would welcome specific mention of it within the Postnatal Care guidance. Office for National Statistics. Childhood mortality in England and Wales: 2015. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018 Office for National Statistics. Unexplained death in infancy, England and Wales: 2015. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/unexplaineddeathsininfancyenglandandwales/2015 [Accessed 14/11/2017]. Moon R, Hauck F, Colson E. Safe infant sleep interventions: what is the evidence for successful behaviour change? Curr Pediatr Rev. 2016;12:67-75. Pease A, Ingram J, Blair PS, Fleming PJ. Factors influencing maternal decision-making for the infant sleep environment in families at higher risk of SIDS: a qualitative study. BMJ Paediatr Open. 2017;1:e000133. doi:10.1136/ bmjpo-2017-000133.	
The Lullaby Trust	Guideline	18	5	The use of Baby Check is welcomed, but it should be reiterated that this is designed for babies up to 6 months of age.	Thank you for your comment. We have clarified this in the rationale and impact section.

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The Lullaby Trust	Guideline	40	30	The following comments are given via Professor Colin Morley, who was one of the original researchers and remains linked to us to give advice on the Baby Check process: This is not correct. Babies at home were assessed for the same signs and symptoms as those seen in hospital. Baby Check can identify the four grades of illness severity for any acute illness at home as well as GP practice or at hospital.	Thank you for your comment. We agree that babies in the community and hospital were assessed for the same signs and symptoms, furthermore identified 4 grades of illness severity. We have not reported otherwise. However, we are highlighting that of the studies that met our inclusion criteria for the evidence review (4 studies) that the majority of studies were based in hospital (Morley 2001, Chandran 1998 [polyclinic], Chen 1997, and Thornton 1991) compared to the community (Morley 1991).
The Lullaby Trust	Guideline	41	8	It is stated here that he use of BabyCheck by parents has not been validated. At the Lullaby Trust we support families through our Care of Next Infant programme (CONI) which offers additional health visitor support for families who have experienced the death of a previous baby. We monitor Baby Check use and feedback regularly. In 2020, 60% of CONI families reported using BabyCheck, 80% of those found it very useful or useful, and 50% continue to use it after the overall CONI programme ended. In addition, Professor Colin Morley added: Baby Check has been used with parents. See attached references.[listed below] Although theoretically it would be good to assess the accuracy of the scores obtained by parents is just not possible for a paediatrician to go immediately and assess the child themselves. Two papers have reported the use of Baby Check at home. One scoring the baby's daily for one week and the other where mothers used Baby Check when they	Thank you for your comments. We agree that the usefulness of the Baby Check scoring system has been explored by parents, however this was not an outcome of interest for our review. The critical outcomes of interest for this review were sensitivity and specificity, we found no studies with relevant data so we could calculate the outcomes for parents, thus the diagnostic accuracy of the scores by parents have not been validated.

				wanted to over six months. In the second study a trained research nurse visited and assessed the baby wat 8 and 16 weeks old. Most of the mothers' scores were less than 8. Ten babies (10%) had 18 contacts with the health visitor midwife or doctor, mostly for minor complaints. 6 reported that Baby Check had helped them decide whether or not to seek advice; 4 were reassured by a low score, and scores of and 15 and 19 prompted them to seek advice: one baby had a chest infection and the other had asthma and a severe cold.	
The Lullaby Trust	Guideline	41	016 - 018	This sentence states that parents should be given Baby Check before their baby is unwell so they are not seeking to use it when they have concerns. It should also be noted here that Baby Check should be encouraged to be used when a baby is well so the parents are used to the scoring and their baby.	Thank you for your comment. This is not something we would recommend as such although it's implied that parents would be familiar with the tool before needing to use it.
The Lullaby Trust	Guideline	43	025 - 026	It is stated here that Baby Check's sensitivity to identify babies whoa re seriously ill varied. This does not take into account the difference between individual babies, meaning seriously ill babies do not always present in the same way.	Thank you for your comment. We agree that seriously ill babies do not always present in the same way, however sensitivity was set out a priori as a critical outcome in the evidence review for decision making.
The Lullaby Trust	Guideline	44	011 - 013	This states that baby Check should not be used in isolation but as a helpful took in addition to a mother's or doctor's clinical judgement. This is true, but there is also a point around some parents who cannot tell the difference between a mildly ill baby and those who are becoming seriously ill. Likewise a GP may not be able to recognise the difference in an individual baby as well	Thank you for your comment. Yes, this may be the case and that is why we are recommending to consider its use.

				as a parent. Asa tool Baby Check can bring these issues together.	
The Lullaby Trust	Guideline	44	21	The comment on 'red flag' symptoms may be useful, but the Baby Check scoring can help quantify the severity of illness with red flag signs which on their own may not be enough.	Thank you for your comment. The red flags listed are potentially very serious symptoms and signs which most of the time on their own would already warrant seeking urgent medical advice. Most of these are also captured by the initial "screening" in the Baby Check tool. The Baby Check tool can further help by quantifying different symptoms and signs.
UCL	Evidence Review E	General	General	· We were reading your consultation to update the guidelines for postnatal care and noted that you have not identified any evidence under the theme of timing of comprehensive assessment (section E of the draft consultation). However, today we published a large study in BMJ Open based on data from UK primary care (see attachment and link below) which we thought may be of interest? https://bmjopen.bmj.com/content/10/11/e036835 In this cohort study of 309 573 women who had given birth we describe women's uptake of postnatal checks and primary care consultations in the year following childbirth using primary care Electronic Health Records. We found that: Two in 10 women had no consultation at the time of the postnatal check Four in 10 women have no record of receiving a	Thank you for your comment. The study by Smith et al 2020 doesn't meet our inclusion criteria as the study doesn't compare women who received a post-natal routine assessment vs women who did not receive a post-natal routine assessment.

				structured postnatal check within the first 10 weeks after giving birth, this is despite the majority of women returning to primary care at least once in the year after childbirth. Teenagers and those from the most deprived areas are among the least likely to have a check. We estimate up to 350 400 women per year in the UK may be missing these opportunities for timely health promotion and to have important health needs identified after childbirth.	
UNICEF UK	Guideline	5	9	We support the committee's decision to place a time frame around the first visit following transfer of care from the place of birth. We also support that this visit is by a midwife and is face to face. We agree that this will enable a comprehensive assessment of the mothers and her baby's needs	Thank you for your comment. Based on stakeholder feedback we have slightly revised this recommendation to state that the timeframe for the first midwife visit should be within 36 hours (instead of between 12 and 36 hours).
UNICEF UK	Guideline	6	3	We were interested in the recommendation that there should be consideration given to a visit by a health visitor one to two weeks after transfer of care from the midwifery team. This risks mothers not being seen between day 10 and day 24, because this meets service needs rather than mothers, a very vulnerable period for mothers particularly with feeding and perinatal mental health. Preferably handover should involve the midwife, HV and mother making a joint decision on visits based on need.	Thank you for your comment. The reason for the timeframe suggested in this recommendation is to spread the visits during the first 8 weeks more evenly so that the family is not left without a visit by a healthcare professional for many weeks during the first weeks after birth. The committee's concern was that in current practice, there is often a gap of even 6 weeks between the first health visitor visit and the second postnatal health visitor visit and this may risk not identifying concerns, including mental health concerns in a timely manner. The recommendation to consider spreading the visits more evenly is in the

					interest of the family, not the service provider. We have also added a recommendation about ensuring that the transfer of care between midwifery and health visitors are clearly communicated between the healthcare professionals and the to the woman/family so that there is no uncertainties, this will also allow for the timing to be tailored if needed. Furthermore, we have added a recommendation about giving information about available support during the postnatal period, including statutory and voluntary services.
UNICEF UK	Guideline	6	19	We were pleased to note the specific guidance around communication between health professionals at transfer of care however we would recommend the addition of a bullet point specifically referencing information sharing around feeding including any issues that have arisen	Thank you for your comment. We have added this to the recommendation.
UNICEF UK	Guideline	9	12	We welcome the inclusion of breast comfort and inflammation however we recommend that 'signs of mastitis' is included with a link to NICE guidance	Thank you for your comment. We have added symptoms and signs of mastitis to the list of potentially serious conditions that women should be aware of and seek medical advice if they occur. We are not sure which NICE guideline is suggested to be referenced.
UNICEF UK	Guideline	14	28	There is clear advice on identifying and managing jaundice and we commend this however we recommend that managing babies at risk of hypoglycaemia is also included in this section with links to the British Association of Perinatal Medicine guidance to ensure safety for the babies at risk in the early postnatal period	Thank you for your comment. The British Association of Perinatal Medicine guidance has not been accredited by NICE so we have not made a reference to it.

UNICEF UK	Guideline	15	10	We strongly recommend that 'references to planning and managing babies' feeding' should link directly to the Baby Friendly Initiative standards for maternity services and all further references to managing feeding babies throughout the document should also link to these standards. It is clear that the committee discussed the variation in practice across maternity services and produced the guidance with the aim of improving consistency however since the guidelines were written NHS England and Unicef UK Baby Friendly Initiative has agreed a joint support offer for all maternity services to achieve full accreditation by March 2024. Therefore, the most effective way to ensure consistency will be for maternity services to adopt the standards in practice, Baby Friendly initiative also has a rigorous assessment process to ensure standards are met and embedded in practice.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
UNICEF UK	Guideline	16	1	We welcome the guidance on bedsharing which is consistent with current evidence and ensures parents have a discussion around safe practices as well as clear advice on when not to share a bed. This practice will enable consistency across maternity services.	Thank you.
UNICEF UK	Guideline	17	2	The section on emotional attachment is welcomed. We recommend a link to the Baby Friendly standards for maternity services here as these specify when and how to achieve this and provide links to materials for parents.	Thank you for your suggestion. The committee were unable to cross refer to the Baby Friendly standards because these are not NICE accredited.

UNICEF UK	Guideline	17	21	We recommend that maternal mental health issues should be considered as a separate bullet when additional support may be required.	Thank you for your suggestion, in response to which the committee agreed to add 'psycho-social needs' as one of the reasons parents may need additional support for bonding and emotional attachment.
UNICEF UK	Guideline	19	22	We question the use of GORD as a red flag for serious illness – we recommend using a more appropriate example such as pyloric stenosis as GORD is frequently misdiagnosed when there is GOR	Thank you for your comment. Actually, GORD is not listed as a red flag in this recommendation but the NICE guideline on GORD is referenced to contain more information because it lists red flag symptoms which suggest disorders other than GOR. This guideline, among other NICE guidelines, was used as a source for the list of red flags and is thus referenced as a source for more information.
UNICEF UK	Guideline	20	004 - 009	We welcome this section on communication including the link to recommendations on communication with women. These principles are included in the Baby Friendly initiative standards and it would be helpful to reference this.	Thank you for your comment. The UNICEF BFI guidelines have not been accredited by NICE so we have not made a reference to them in the recommendations. However, we think that our recommendations do not contradict their guidance and overall they align well.
UNICEF UK	Guideline	20	10	We agree that a discussion should take place before birth, however we strongly recommend linking to the Baby Friendly standards here. Discussions on infant feeding are nuanced and can be difficult to get right. Baby Friendly have evidence based guidance and materials that support health professionals to have these conversations.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
UNICEF UK	Guideline	20	15	We question the emphasis on discussing nutritional benefits to the baby when most parents are aware of the nutritional aspects of breastfeeding. The impact on this discussion could mean less time to have an	Thank you for your comment, which the committee discussed. They had no particular reason for beginning this list with 'nutritional benefits' and highlighted that these items are not shown in any priority order and are

				open discussion on what the parents already know, how they feel and giving them additional information as appropriate.	simply examples of topics to discuss. They therefore did not change the sequencing.
UNICEF UK	Guideline	21	2	We welcome the discussion on the benefits even if only done for a short while providing that this is contextualised and tailored to individual women's intentions, not a blanket statement for all women.	Thank you for your comment. The committee agrees. Individualising the communication to fit the needs, preferences and circumstances of the women is recommended in the 'Principles of care' section and underpins all the discussions with the woman.
UNICEF UK	Guideline	21	3	We welcome the discussion in the guidance around the relationship between breastfeeding and soothing and comforting	Thank you.
UNICEF UK	Guideline	21	6	We welcome giving partners information around their involvement as it is well evidenced that this support is crucial to successful breastfeeding	Thank you.
UNICEF UK	Guideline	21	7	We agree that partners receiving information around how they can comfort and bond with their baby is a positive way to ensure they realise they do not need to feed their baby to build a close and loving relationship	Thank you.
UNICEF UK	Guideline	21	012 - 018	We agree that health professionals need to have adequate knowledge around breastfeeding, however we strongly recommend that this section be clarified regarding the training required as the bulleted points would not be adequate to support a mother to successfully feed her baby. The topics listed don't work as stand-alone topics and there is no mention of how a baby breastfeeds. We suggest an evidence based training programme that covers the knowledge and skills required to implement the Baby Friendly standards in practice. That way the guideline will cover	Thank you for your comment. Training and issues around competencies of healthcare professionals are not in the remit of this guideline but we have stated some basic knowledge that healthcare professionals caring for women and babies in the postnatal period should have.

				the inseparable needs of health professionals to understand breastfeeding, formula feeding, early attachment, problem solving, and communication related to infant feeding. This could be delivered by the university, Baby Friendly Initiative or in-house by a trained infant feeding lead using the Baby Friendly materials.	
UNICEF UK	Guideline	22	1	We agree that babies should have an early breastfeed however we are concerned that encouraging mothers to start breastfeeding as soon as possible may have the impact of women moving their baby and trying to breastfeed well before the baby is ready causing distress for both. We suggest the guidance encourages women to have skin to skin contact with their baby immediately after birth and offer the first breastfeed in skin to skin contact when the baby shows signs of readiness to feed, ideally within one hour after birth	Thank you for your comment. We have changed the recommendation to reflect this.
UNICEF UK	Guideline	22	003 - 011	We strongly recommend that this section should link directly to the Baby Friendly Initiative standards for maternity services. NHS England and Unicef UK Baby Friendly Initiative has agreed a joint support offer for all maternity services to achieve full accreditation by March 2024. Therefore, the most effective way to ensure consistent, well evidenced breastfeeding support will be for maternity services to adopt the Baby Friendly Initiative standards in practice, Baby Friendly initiative also has a rigorous assessment process to ensure standards are met and embedded in practice	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.

UNICEF UK	Guideline	22	1.5.10	Again, we strongly recommend that this section should link directly to the Baby Friendly Initiative standards for maternity services. NHS England and Unicef UK Baby Friendly Initiative has agreed a joint support offer for all maternity services to achieve full accreditation by March 2024. Therefore, the most effective way to ensure consistent, well evidenced breastfeeding support will be for maternity services to adopt the Baby Friendly Initiative standards in practice, Baby Friendly initiative also has a rigorous assessment process to ensure standards are met and embedded in practice.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
UNICEF UK	Guideline	22	General	We strongly recommend that this section links directly to the Baby Friendly Initiative standards for maternity services. NHS England and Unicef UK Baby Friendly Initiative has agreed a joint support offer for all maternity services to achieve full accreditation by March 2024. Therefore, the most effective way to ensure consistent, well evidenced breastfeeding support will be for maternity services to adopt the Baby Friendly Initiative standards in practice. The Baby Friendly initiative also has a rigorous assessment process to ensure standards are met and embedded in practice.	Thank you for your comment. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, the committee arrived at conclusions that generally align with the material in UNICEF's BFI.
UNICEF UK	Guideline	23	1	We agree with the guidance on information about opportunities for peer support	Thank you.
UNICEF UK	Guideline	23	002 - 004	We are pleased to see the guidance on making face to face support integral to the postnatal contacts. This will have a positive impact on addressing problems early and	Thank you for your comment. The evidence located by the review on breastfeeding support showed that women had a preference for support to be provided in

				sustaining breastfeeding. However, recently it has been demonstrated that video calls can also support breastfeeding effectively. Even after the pandemic they could become part of a triage system for breastfeeding support, allowing resources to go further.	person, face to face. Although the use of video conferencing has perhaps become more common in recent months the committee did not feel they had any evidence to show that preferences for face to face support had shifted. The committee therefore did not feel there was a strong basis for any change to this recommendation.
UNICEF UK	Guideline	23	005 - 008	We are pleased to note the guidance for extra support and encouragement for younger women and those on low income or disadvantaged background	Thank you.
UNICEF UK	Guideline	23	14	We were pleased to note the use of the term responsive breastfeeding.	Thank you.
UNICEF UK	Guideline	23	17	A link to the Baby Friendly breastfeeding assessment tool would be useful here. This is widely used across maternity services and is the most comprehensive tool for assessing effective breastfeeding.	Thank you for your comment. The UNICEF BFI breastfeeding assessment tool is not a validated tool so we have not reviewed it and critically appraised it. Therefore, we have not linked to the UNICEF BFI in the recommendations. However, we have made a reference to it in the rationale and impact section.
UNICEF UK	Guideline	23	26	Fatigue is not particular to breastfeeding. This line compounds the myth that breastfeeding is in and of itself tiring and so should be removed.	Thank you for your comment. The committee are aware that fatigue is not unique to breastfeeding but they agree that the management of fatigue is very different in this context because if formula feeding then feeding can be handed over to allow the mother to catch up on sleep, for example. To clarify this, they agreed to edit the recommendation, which now refers to strategies to manage fatigue when breastfeeding.

UNICEF UK	Guideline	23	27	This line is badly written, it is not appropriate to suggest discussing the advantages of supplementary feeding with no context given. Suggest replacing with 'supplementary feeding and how to avoid this unless clinically necessary'.	Thank you for your comment. We have revised this section based on the feedback to say "supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated".
UNICEF UK	Guideline	24	004 - 015	A link to the Baby Friendly breastfeeding assessment tool would be helpful here. The Baby Friendly standards require two formal assessments within the first week but do not specify the timing. Requiring an assessment within the first 24 hours could be very early for some women as many indicators will not yet be present. An alternative could be to require an assessment before discharge from hospital and then two more assessments in the first week.	Thank you for your comment. The UNICEF BFI guidelines have not been accredited by NICE so we have not made a reference to them in the recommendations. However, we think that our recommendations do not contradict their guidance and overall they align well and we refer to it in the rationale and impact section which explain the recommendation.
UNICEF UK	Guideline	25	002 - 003	Discussing formula feeding in the antenatal period is more complex than this statement implies. It would be better if antenatal discussion around infant feeding was kept to one point in the guideline which emphasises the need for a meaningful conversation that takes into account individual circumstances and covers breastfeeding, formula feeding and relationship building as applicable to need.	Thank you for your comment. The committee carefully considered the lay out of the recommendations about infant feeding. They did not feel it was helpful to make a distinction between the areas covered in antenatal and postnatal discussions about formula feeding as this is likely to vary according to circumstances and preferences and the key is to ensure these areas and topics are covered, whether antenatally or postnatally. The committee did however add to the recommendation starting off the section on formula feeding to emphasise formula and breastfeeding are not necessarily mutually exclusive.
UNICEF UK	Guideline	25	004 - 011	As above, the information listed here is suitable for parents who have chosen to	Thank you for your comment. The committee agreed that those women who need to formula feed or those who are considering

				formula feed in the postnatal period, but not necessarily during the antenatal period.	formula feeding should be given information about formula feeding already before birth so that informed decision can be made and so that if done, it can be done safely and appropriately. The discussions should of course continue in the postnatal period and perhaps more detailed information is more appropriate only when the feeding has started.
UNICEF UK	Guideline	25	017 – 022	As stated above in relation to breastfeeding, many services have found that video calls have worked successfully to support formula feeding during the pandemic. A link to the Baby Friendly bottle feeding assessment tool would support the effective and consistent implementation of this section.	Thank you for your comment. Although the committee acknowledge your point about the recent growing importance of providing support via video conferencing they do not feel they have evidence to show it is working as well as in person, face to face support. The committee therefore did not feel there was a strong basis for any change to this in the recommendations. Guidance from other developers which has not been accredited by NICE cannot be referenced or linked to in the recommendations. Therefore, we have not linked to the UNICEF BFI in the recommendations.
UNICEF UK	Guideline	26	008 - 009	This point would benefit from including 'offer further support and information around the benefits of continuing to give some breastmilk and how to mixed feed'	Thank you for your comment. This issue is covered in an earlier recommendation where the issue about giving information about the possible effects of formula supplementation on breastfeeding success, and how to maintain adequate milk supply while supplementing.
UNICEF UK	Guideline	17	15	The bullet point on feeding as a challenge to emotional attachment is misleading as it implies that feeding is always challenging which is not the case. Feeding is also known to greatly enhance attachment when going	Thank you for your comment. We have revised it to say "feeding concerns".

				well. We recommend that this bullet is either clarified or removed.	
UNICEF UK	Guideline	General	General	We thank the guideline committee for the opportunity to comment on this document and appreciate the volume of work that has been undertaken	Thank you.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	4	7	Bladder function: measuring void or bladder scan – no guidance on when a bladder scanner should be used, more detail required.	Thank you for this comment, however, the guideline is not attempting to provide the detail of a text book so this type of information is not provided. Also, evidence on this was not reviewed.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	4	13	We are concerned that this is insufficient and this assessment must be set within a broader context of relational care.	Thank you for your comment. Other sections of the guideline cover various aspects of communication and support provided to the families which relate to time points of postnatal care, including the period of transfer to community care. This section is generally about checks and discussions done to enable and facilitate transfer to community care.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	9	3	Involution and palpating the uterus not mentioned as a tool to aid diagnosis.	Thank you for your comment. This section is not attempting to give detailed advice on how to assess the different aspects of physical health therefore we have not included this in the recommendation.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	10	11	Specify who. Maternity services, health visitor, GP.	Thank you for your comment. We have specified that this should be done by a GP.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	13	5	Validated scale, give examples.	Thank you for your comment. Our review on tools for clinical review of women, including pain scores, did not identify any pain scales for this population in particular (Evidence review H), however, there are various pain

					scales validated in the general population to which postnatal women arguably belong. Two such scales were used in the study included in the review on perineal pain (Evidence review J). We have not to give examples as we have not evaluated these scales.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	15	21	Baby Check scoring system – not validated	Thank you for your comment. We agree that the Baby Check scoring system for serious illness has limitations, which are fully discussed in the rationale and impact section and in the benefits and harms section.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	16	9	Bed sharing not advised if baby of low birthweight or pre-term – this is not mentioned	Thank you for your comment. We have not added low birthweight to the recommendation. Preterm babies are outside the scope of this guideline so this point has not been added to the recommendation, however, we have clarified this in the rationale and impact section.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	20	13	This should include personalising the information to the woman, person and family context, rather than 'explain' it should be 'have a conversation' and share information. Need to include more information about relationship building here. Close and loving relationships and how ongoing skin contact is helpful for maternal and neonatal mental health. Re word breastfeeding has benefits. Implies that breastfeeding is not always beneficial	Thank you for your comment. We have revised this section so that the bullets listed could be part of the general discussion about breastfeeding. We have also made a reference to the more detailed recommendation later in the guideline about various aspects of breastfeeding that could be discussed.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	22	1	Support should be given to initiate skin to skin to support breastfeeding asap, avoid interrupting babies in skin contact until after the first feed or women/person's choice.	Thank you for your comment. We have changed the recommendation to emphasise skin-to-skin contact.

University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	22	3	Physical assistance should not be given – implies hands on	Thank you for your comment, which the committee discussed. They concluded that in fact some people do want to have physical help with feeding and that if this is the case it should be permissible with their clear consent.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	23	027 - 029	The advantages of supplementation with formula milk?! - how bf can affect the woman's body image and identity implies negativity. Not sure about the wording of discussing the 'advantages and disadvantages' of supplementary feeding – I think there should be wording here regarding the potential risks to milk supply if giving supplementary feeds. Obviously this needs to be sensitive, but I think we're doing women a disservice to discuss 'advantages' of supplementation with formula milk unless there is a medical need when they are trying to establish breastfeeding.	Thank you for highlighting this. The committee agreed to remove this reference to 'advantages and disadvantages of supplementary feeding' and this recommendation now simply refers to one of the included topics for discussion being 'supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated'.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	26	11	Sparingly expressing will not help suppressing lactation in the longer term - possibility of becoming a breast milk donor maybe insensitive and irrelevant given the lack of milk banks around the country Suggests weighing 'in the first week' and then at 8 weeks if no problems suspected. The visit pattern recommended i(in 1.1.4) is that the HV visits some 7-14 days after discharge from midwifery care. Does this potentially leave babies for too long in that early period without weight monitoring? I realise we should be relying on other signs of good feeding but with midwifery services stretched to capacity I'm not sure this is	Thank you for your comment. Sparingly expressing eases breast engorgement and can potentially avoid adverse outcomes such as mastitis. The committee aware and discussed that milk banks are not available everywhere. This had not been previously captured in the discussion section of the evidence review and we have now added some discussion around this. In relation to the comment on weight monitoring. The schedule for weight monitoring is derived from the UK-WHO Growth Charts and is in addition to the assessment of the baby's health, wellbeing and feeding. The individual recommendations are done in conjunction

				realistic and have seen weight losses after an initial reassuring weighing many times.	with the other recommendations in the guideline forming a holistic approach to postnatal care. Therefore, for the recommendation on weight monitoring to be sufficient and sensible, we need to assume that the baby's health and wellbeing is assessed as well.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	General	General	It would be useful to capture at some point in the guidelines that the people in our care may not identify as 'women' and so either a statement to identify why the use of the term 'woman' needs to be articulated. Or the addition of woman and person need to be included together. Think it is important to retain the use of the word woman but also add the word 'person' too. E.g. Childbearing women and people.	Thank you for your comment. This type of statement was made in the beginning of the document and will be made in the final published guideline as well.
University of Central Lancashire – MAINN and ReaCH midwifery research centres	Guideline	General	General	More focus on the relationship between women, people babies and families is important to reflect the evidence underpinning the Baby Friendly Initiative. This is also important for perinatal mental health and infant mental health.	Thank you for your comment. The section on promoting emotional attachment is all about the parent-infant relationship. We also think other sections, including the feeding section have a focus on the relationship between the baby and the parents.
WaterWipes	Guideline	15	8	The draft proposed guideline (GID-NG10070) states: Give parents information about: • how to bathe their baby and care for their skin However, we are concerned this does not provide enough guidance. In current guidance, for topping and tailing/bathing, parents are advised to use cotton wool and water/cloth and water. We are concerned that parents are being advised on procedures which are outdated. It would be beneficial for NICE to include some guidance on procedures and suitable	Thank you for your comment. We have not reviewed evidence on the issue of baby's skin care and have therefore not made any detailed recommendations around this.

				products for bathing/topping and tailing babies. In this additional guidance, we would ask that suitably formulated baby wipes (i.e. perfume-free with minimal ingredients) are considered as acceptable products.	
WaterWipes	Guideline	General	General	Following review of the current guideline, we are concerned that they are confusing and do not provide adequate guidance for Healthcare Professionals to advise parents, especially around the area of infant skin care. There have been no specific guidance/recommendations provided by NICE to date. Resulting in a wide variety of contradictory recommendations given by Healthcare Professionals to parents. In the current guidelines (CG37 1.4.23), it states: 1.4.23 Parents should be advised that cleansing agents should not be added to a baby's bath water nor should lotions or medicated wipes be used. The only cleansing agent suggested, where it is needed, is a mild non-perfumed soap. [2006] “Baby Wipe formulations have improved significantly in the last 40 years, abrasive ingredients, such as isopropanol are no longer added, and many brands exclude perfume as recommended by NICE”1. However, we are concerned that there is confusion around the terminology “medicated” and “non-medicated” wipes. This confusion is due to the NICE guideline which states medicated wipes should not be used. This may result in Healthcare Professionals interpreting this as all non-medicated wipes are suitable. However, this	Thank you for your comment. Infant skin care was not prioritised during the scoping process as a topic to be covered by this guideline and therefore we have not reviewed evidence on it or made recommendations on this issue.

				raises some questions i.e., what are non-medicated wipes, is there a list of what NICE considers non-medicated? Does it refer to the number of ingredients? Some baby wipes have up to 23 ingredients in comparison some have minimal ingredients which would be more suitable for babies' skin. In our opinion, non-medicated wipes are those with minimal ingredients. Recent studies have shown that the use of fragrance free, non-medicated wipes with minimal ingredients can be advantageous for skin care as well as providing increased convenience compared to the current guidance provided (i.e. cotton wool and water). Some of studies which support this theory are as follows; A recent publication from the University of Salford on how different formulations can impact the skin integrity of 698 new-borns demonstrated that babies cleansed with WaterWipes are less likely to get moderate to severe nappy rash, and if they do, it lasts fewer days compared to other leading brands. The BaSICS paper demonstrated that mothers using WaterWipes on their babies' skin had a lower incidence of nappy rash* (19%), compared to those cleansed with brand one (25%) or brand two (30%). For each day of nappy rash* experienced by the WaterWipes babies, the rash would have lasted approximately 50% longer had mothers used other brands – 1.69 days with brand two ($p<0.001$) and 1.48 days with brand one ($p=0.002$). This study was funded	

				by WaterWipes. The researchers involved in the analysis of the data were blinded to the baby wipe brand. Moderate to severe Reference: Price AD et al., The BaSICS (Baby Skin Integrity Comparison Survey) study: A prospective experimental study using maternal observations to report the effect of baby wipes on the incidence of irritant diaper dermatitis in infants, from birth to eight weeks of age, Pediatrics and Neonatology, https://doi.org/10.1016/j.pedneo.2020.10.003	
WaterWipes	Guideline	General	General	A recent publication from the University of Utah Hospital on perineal skin care of 1070 babies over a 12-month period in a NICU unit demonstrated that a good cleansing regime + use of WaterWipes™ resulted in shorter duration and reduced incidence of less severe diaper dermatitis (nappy rash) in a large study. The Utah hospital paper demonstrated the WaterWipes™ is well tolerated by NICU babies of all gestational ages. After implementation of the new skin care guidelines of which WaterWipes™ was an integral part, the average incidence of diaper dermatitis reduced from 45.5% to 38% a, a 16.7% reduction. In the subsection classed as suffering from Severe DD, after implementation of the new skin care guidelines of which WaterWipes™ was an integral part, the incidence of severe DD decreased by 34.9% and the duration reduced by 3.5 days per 100 patient days a 57.4% reduction. This was independent	Thank you for your comment. Infant skin care was not prioritised during the scoping process as a topic to be covered by this guideline and therefore we have not reviewed evidence on it or made recommendations on this issue.

				research not funded by WaterWipes™ Reference: Advanced Neonatal Care. 2020 Sep 30. doi: .1097/ANC.0000000000000795. Online ahead of print. A Quality Improvement Approach to Perineal Skin Care: Using Standardized Guidelines and Novel Diaper Wipes to Reduce Diaper Dermatitis in NICU Infants Sue Rogers 1, Micaela Thomas, Belinda Chan, Spencer K Hinckley, Carol Henderson	
WaterWipes	Guideline	General	General	We are concerned that there is a lack of guidance on nappy rash provided in the current guidelines (CG37) but also that it has not been addressed in the draft guidance (GID-NG10070). The current guidance (CG37) states: 1.4.28 For babies with nappy rash the following possible causes should be considered: hygiene and skin care sensitivity to detergents, fabric softeners or external products that have contact with the skin presence of infection. [2006] We feel that there needs to be additional guidance on the proper skin care of the diaper area and how good hygiene and cleaning regimes can reduce the likely hood of developing this skin condition. We would like to see guidance/recommendations which address this, but also address types of products which are acceptable for use in these situation. Based on the information presented in both the BaSICs1 study and the Utah2 study, we believe suitably formulated wipes (i.e. those with minimal ingredient) are advantageous in the cleaning regime of the	Thank you for your comment. Infant skin care, including nappy rash, was not prioritised during the scoping process as a topic to be covered by this guideline and therefore we have not reviewed evidence on it or made recommendations on this issue.

				nappy area.Reference: Price AD et al., The BaSICS (Baby Skin Integrity Comparison Survey) study: A prospective experimental study using maternal observations to report the effect of baby wipes on the incidence of irritant diaper dermatitis in infants, from birth to eight weeks of age, Pediatrics and Neonatology, https://doi.org/10.1016/j.pedneo.2020.10.003 Advanced Neonatal Care. 2020 Sep 30. doi: .1097/ANC.0000000000000795. Online ahead of print. A Quality Improvement Approach to Perineal Skin Care: Using Standardized Guidelines and Novel Diaper Wipes to Reduce Diaper Dermatitis in NICU Infants Sue Rogers 1, Micaela Thomas, Belinda Chan, Spencer K Hinckley, Carol Henderson	