Postnatal care up to 8 weeks after birth (update)

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Action on Smoking and Health (ASH)	General	General	ASH welcomes the reference to NICE Guidance ph26 on stopping smoking during pregnancy and after childbirth. However, given the significant risk posed by smoking and exposure to secondhand smoke to babies, we feel there is not sufficient evidence that this has been considered in the Scope risking it being excluded from future guidance. ASH has recently undertaken a literature review on reducing pregnant women's exposure to secondhand smoke, and feel that NICE Guidance could benefit from taking account of this growing body of evidence which also has a baring on postnatal care.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, the scope would allow for recommendations on smoking to be made in several places, for example question 2.1 on information needed for self-care. This would depend on the amount and quality of evidence.
Action on Smoking and Health (ASH)	General	General	The draft scope excludes the principle of providing a safe home environment for new-born babies and the role of health visitors, midwives and other healthcare professionals in this. Where parents are smoking in the home, this is not a safe environment for a new-born baby. Smoking is a leading cause of sudden infant death syndrome, and it's estimated that 30% of sudden infant deaths could be prevented if children were not exposed to tobacco smoke (BMA, 2004). Smokefree homes should primarily, be established during pregnancy where smoking or exposure to tobacco smoke is a serious risk factor. However, where this has not been achieved it is essential that post-natal care addresses this risk with all parents and care givers. Midwives, health visitors and other healthcare professionals should all be able to provide Very Brief Advice (VBA) on smoking, encourage parents to keep a smokefree home and sign-post to stop smoking services. This is a key step to preventing morbidity and mortality among infants which is listed as 'Mains Outcomes 7 and 8.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, the scope would allow for recommendations on smoking to be made in several places, for example question 2.1 on information needed for self-care. This would depend on the amount and quality of evidence.

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			This should be included in 'Key Issues and Questions' section 3: 'Identifying and assessing health needs in babies'. All babies need a smokefree home in which to be safe from morbidity and mortality.	
Action on Smoking and Health (ASH)	General	General	**The draft scope currently excludes the idea of preventing future ill health both in mothers and in infants. If parents do not change their behaviours during the first 1000 days of a baby's life the chance of that behaviour change is significantly lowered. Therefore, healthcare professionals providing post-natal care are crucial in giving advice and behavioural support which will support the health of the family and child moving forwards. Healthcare professionals and especially health visitors must be able to discuss smoking behaviours with new parents and wider family members in order to protect children from future ill health. The Royal College of Physicians' report Passive Smoking and Children estimates that exposure to tobacco smoke leads to an additional 300,000 GP appointments each year among children. The report further estimates that over 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear disease, and at least 22,000 new cases of wheeze and asthma are all caused by passive smoking in children each year in the UK.**	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, the scope does allow for lifelong assessment of maternal and infant health and therefore if there is evidence of lifelong quality of life improvement for - for example - smoking advice and behavioural support, the committee could use this information in drafting their recommendations.
Action on Smoking and Health (ASH)	General	General	The Institute of Health Visiting definition of a health visitors states that their role includes: "enhancing health and reducing health inequalities" (IoHV). Smoking is a leading cause of health inequalities responsible for roughly half the difference in life expectancy between rich and poor in the UK. Children growing up around smokers are not only more exposed to the risks of secondhand smoke but are also three times more likely to become	Thank you for your comment. All NICE clinical guidance attempts to reduce health inequalities through providing high-quality evidence-based

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			smokers themselves, perpetuating a cycle of inequality. There is no indication that health inequalities have been considered by the draft scope.	recommendations. If there is evidence that a particular intervention can reduce health inequalities, the committee may wish to consider this in drafting their recommendations.
Action on Smoking and Health (ASH)	2	16-19	The Scope here discusses the fact that 45% of pregnancies are unplanned and therefore health visiting can be an opportunity to promote health for any subsequent pregnancies. Smoking is the number one modifiable risk factor for still birth (Royal College of Physicians. Smoking and the young) and contributes to approximately 5000 miscarriages a year (RCP. Passive Smoking and Children). If health visitors are able to address maternal smoking and the impact of it on children after birth there is the potential to improve the health of future pregnancies and reduce risk of complications. Health visitors have a unique opportunity to promote health when women and their partners are likely to be especially receptive to this.	Thank you for your comment. The committee will have an opportunity to consider the health promotion advice which could be given in question 1.5 on the content of postnatal care contacts. We cannot pre-empt what recommendations they will make, as this depends on what evidence is uncovered.
Action on Smoking and Health (ASH)	19	9 (Main Outcomes)	Under the main outcomes for the scope are listed: 'maternal mortality and maternal morbidity' and 'baby mortality, baby morbidity and baby growth'. Addressing the smoking behaviour of parents is the single most important	Thank you for your comment. If there is evidence linking smoking to

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			thing a health visitor could do to help improve these outcomes. Half of all smokers will die from their addiction, smoking leads to additional complications both during pregnancy and after childbirth and parental smoking is a leading risk factor for sudden infant death and infant morbidity.	subsequent mortality or morbidity the committee will be able to consider this when drafting their recommendations.
Association of Breastfeeding Mothers	1	26	We recommend that relationship building is added to line 26, knowing the long and short term outcomes for health and well-being. Unicef, 2012, The Evidence and rationale for the Unicef UK Baby Friendly Initiative Standards. Unicef 2017Early Moments Matter: for every child	Thank you for your comment. We have made the change you suggested.
Association of Breastfeeding Mothers	3	4	As one of the voluntary breastfeeding organisations in the UK we would recommend that a bullet point is added after line 4 reading "Voluntary/peer infant feeding supporters."	Thank you for your comment. We have added a line reading that the guideline might be relevant to 'other organisations providing support in the postnatal period up to 8 weeks after birth (for example, voluntary/peer infant feeding supporters)'.

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Association of Breastfeeding Mothers	4	11	Although previously mentioned emotional wellbeing of mothers is not mentioned in the bullet points. We recommend the key area 2 is amended to include this.	Thank you for your comment. We have made the change you suggested.
Association of Breastfeeding Mothers	4	12	The early relationship impact on the baby is profound and we recommend amending key area 3 to include this.	Thank you for your comment. After discussion with the technical team we elected not to change key area 3 as you suggest, but instead to treat attachment / relationship outcomes as outcomes across all review questions where it is relevant. This should allow a wider-reaching assessment of this very important outcome.
Association of Breastfeeding Mothers	11	First point - how should breastfeeding be assessed?	If mothers and clinicians do not know what effective breastfeeding looks like then readmission for jaundice and weight loss can occur due to ineffective transfer of milk. We recommend it is important to add a review question to ensure there are assessment tools available. (eg Unicef Baby Friendly Breastfeeding Assessment Form)	Thank you for your comment. A separate question on the assessment of successful breast feeding was not prioritised as we expect these indicators to arise from question 4.5 on

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				interventions which promote successful breastfeeding. The outcomes for this question will be chosen by the multidisciplinary committee as to represent 'successful' breastfeeding, based on their professional experience and knowledge of the topic. We will follow the GRADE methodology (which requires identifying critical and important outcomes). This should allow the committee to make more nuanced recommendations on this very important topic, because it will mean assessment can be considered across all feeding questions.

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Association of Breastfeeding Mothers	12	Third point – are there any interventions that promote attachment/bonding in the postpartum period?	Throughout the scoping document we have talked about the importance of feeding on the relationship between the mother and baby, so although referral back to the NICE guidance on antenatal and postnatal mental health we would recommend an additional question in these guidelines also. Additional review question: What information and support should be provided to mothers on the association between infant feeding and relationship building? Unicef, 2012, The Evidence and rationale for the Unicef UK Baby Friendly Initiative Standards. Unicef 2017Early Moments Matter: for every child	Thank you for your comment. Attachment / bonding will be an outcome for all review questions where it is appropriate, and so therefore if there is evidence that feeding promotes bonding the committee will be able to recommend explaining that to the mother.
Association of Breastfeeding Mothers	13	Seventh point – what is the risk of co sleeping in relation to sudden infant death syndrome?	We would recommend that a review question is included for this point. Evidence from www.isisonline.org.uk Unicef UK Baby Friendly Initiate, ISIS, The Lullaby Trust, 2017, Co-sleeping and SIDS: A guide for health professionals Suggests that separation of the mother and baby impacts on not only breastfeeding but building close and loving relationships. Review question: What information and support should mothers receive on where their baby should sleep?	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant

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				sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"
Association of Breastfeeding Mothers	18	27,28	We would recommend that information about where babies should sleep should be added into this question.	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"
Association of Breastfeeding Mothers	19	18	Main outcomes Maternal outcomes – 6 emotional attachment and Baby outcomes: 12 social and emotional development These need to be included in the key issues and questions section if they are to be listed as outcomes. Suggest: Page 18 line 12 to read 2 Identifying and assessing the health and wellbeing needs in women Page 18 line 24 to read Identifying and assessing the health and wellbeing needs in babies Page 18 line 27/28 to read 3.2 What information should be given to parents on routine care of babies, including where their baby should sleep? Page 18-19 add to section 4 Planning and management of babies feeding 4.6 What tools for clinical review of breastfeeding are effective during the first 8 weeks after birth 4.7 What information and support should be provided to mothers on the association between infant feeding and relationship building?	Thank you for your comment. NICE processes do not require that main outcomes are explicitly identified with particular review questions. This allows for consideration of one outcome across multiple questions, which we think is the most appropriate way of handling important and holistic outcomes such as attachment and development. We hope this also addresses your final comment on 4.7.

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				We have made the changes you suggest to page 18 lines 12 and 24. We have added two new questions on baby sleeping, "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?" We have removed the question on assessing effective breastfeeding because we will be including the components of successful breastfeeding as outcomes in the breastfeeding review questions. This should allow the committee to make more nuanced

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				recommendations.
Birthrights	General	General	The postnatal period is described as being important to identifying complications and deviations from the norm and as an opportunity to provide information on health and feeding. However the postnatal period is one of the key foundation stones for a healthy family life – not just in terms of physical, and mental health of the woman and baby but also for example promoting healthy bonds between family members, laying the foundations for healthy development of the baby in terms of stimulation etc. We would like to see the scope document recognising the critical role the postnatal period plays in promoting the wellbeing of a family for life not just in the first eight weeks or in subsequent pregnancies.	Thank you for your comment. Although the scope relates only to interventions carried out in the first eight weeks, the outcomes are potentially lifelong (for example parental emotional attachment and baby social and emotional development). Therefore we believe that we can adequately address this comment during development provided there is sufficient evidence on the link between the postnatal period and later outcomes to base recommendations on.

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Birthrights	5	Section 1	Q1."discharge to the home setting" – add "or after the midwives attending labour have left following a home birth" or similar. Q2 add "(where applicable)". Q5 add "or between health care professionals responsible for intrapartum care and healthcare professionals responsible for postnatal care for a home birth"– scope document needs to explicitly recognise all 4 birth settings including home birth.	Thank you for your comment. We have amended the scope to take into account your comment by changing all instances of 'hospital' to 'place of birth' (to explicitly account for all 4 birth settings).
Birthrights	5	Section 1	Q5 this question should include handover between different providers where one provider has been responsible for intrapartum care but another will be responsible for postnatal care.	Thank you for your comment. This was the intention of the question and so it appears we did not communicate our intention clearly enough. We have therefore reworded to improve clarity.
Birthrights	6-10		Maternal health – scope should include how women should be effectively signposted and smoothly transferred (if appropriate) to other services where issues are picked up but not resolved in the first 8 weeks after birth. In addition scope needs to cover links to other guidelines, how to make women aware within the 8 weeks of services they can access after 8 weeks if issues relating to childbirth for example, urinary incontinence do not	Thank you for your comment. The management of maternal health conditions is outside the scope of the guideline, which means that although the committee may be able

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			present (or it becomes clear that these are not a temporary issue) until after the 8 weeks and sometimes much later.	to signpost the correct service to refer to, the transition from routine postnatal care to specialist care cannot be considered as part of the guideline. Depending on the evidence which is found, question 2.1 on information regarding self-care would address services which can be accessed after the 8 week period.
Birthrights	12	(End of section 3)	"Are there any interventions that promote attachment/bonding in the postnatal period?" – not clear that referring to antenatal and postnatal mental health is enough here. In particular we strongly urge that recommendations about not separating mothers and babies/skin to skin with mother and partner should be in scope (for the wellbeing of the baby as well as both parents (where applicable) – antenatal and postnatal mental health focused on mother)	Thank you for your comment. Attachment / bonding will be an outcome for all review questions where it is appropriate, therefore if evidence around these issues is uncovered (for example in evidence review on breastfeeding) then recommendation on

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				the topics you suggest could be made by the committee.
Birthrights	13	Line 2-10	"Areas not covered by the guideline" we would like to be sure that the exclusion of specialist care does not lead to for example, women whose babies are admitted to NICU or who are readmitted for another reason or where the woman is readmitted, to lose out on the "usual" postnatal care they need, as these women often feel they fall through the cracks. These women may also need additional "postnatal care" for example specialist breastfeeding support and the eight week limit may not be appropriate. We know that separation of women from their babies is often an issue in these circumstances.	Thank you for your comment. The guideline will not cover the specialist care of women and their babies (for example care received in a NICU) but will include routine postnatal care of women who have previously received specialist care, as long as this falls within the usual eight week window. Consequently we will not cover the transition between specialist and routine postnatal care as this should be part of specialist guidelines, although we may be able to make recommendations on making routine postnatal

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				care easier to access for those transitioning from specialist settings, if the evidence supports such recommendations.
Breastfeeding Network Scotland	1	25 24-26	Suggest rewording to include women *and their partners* and possibly (especially first-time *parents*) The scope should be broader than health and feeding, women want postnatal care to cover support to gain confidence with understanding their baby and self care following birth and pregnancy	Thank you for your comment. We have made the changes you recommend in the introduction. The full sentence now reads: "In addition, postnatal care services are needed to provide women and their partners (especially first-time parents) with information on health, infant feeding, and relationship building."
Breastfeeding Network Scotland	2	11-19	Recognition of the toll on emotional health as a result of a stretched, and often, poor quality environment within hospital is welcome. Could this, and the awareness that many pregnancies are unplanned and couples	Thank you for your comment. Although we cannot pre-empt

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			unprepared for their new life with their baby, allow for a greater focus on allowing for rest, relationship-building and recovery? The best preparation for a subsequent baby is support through this pregnancy and during the postnatal period. This is where investing in skilled support and consistent, sufficient information reduces subsequent costs. Perhaps this guidance could recommend the return of Birth to Five and the Bottle feeding leaflets, online as a minimum? With line 16-19 – with sentence be expanded to say 'to promote health, wellbeing and care of new parents and infants'	recommendations made by the committee, if there is any evidence on the importance of relationship-building and recovery it can be considered as part of making recommendations.
Breastfeeding Network Scotland	3	13-17	Should the scope include women transitioning to men?	Thank you for your comment. Insofar as their needs are similar to other women then we will ensure that inclusionary language is used throughout the guideline. However insofar as their needs are complex and different we will not be considering women transitioning to men as the population size is too small

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				to uncover robust evidence on the most appropriate management of this group.
Breastfeeding Network Scotland	4	14-18	This is too limited, especially for breastfeeding. No drug is licensed for use by breastfeeding mothers but doesn't mean unsafe just that specialist sources should be consulted – see NICE PH11 rec 15 The summary of product characteristics will almost inevitably say do not use if breastfeeding which will mean interruption of breastfeeding and may expose the infant to infant formula.	Thank you for your comment. Breastfeeding would be an example of an exceptional situation as allowed for by the disclaimer in the scope, and so the committee would be able to consider evidence on drugs for use during breastfeeding as long as there is evidence supporting their use (as with any other intervention).
Breastfeeding Network Scotland	6		Agree, new review question – widened to include partners	Thank you for your comment. After discussion we have elected not to widen this review question as the determination of when and how to share information on the health of

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				the mother should be taken by the mother alone. We cannot pre-empt recommendations made by the committee, but it is possible that information shared with the father / partner could be included in this question without a rewording.
Breastfeeding Network Scotland	7		Treatment for mental health condition should reference r NICE PH11 rec 15	Thank you for your comment. Recommendation 15 in PH11 refers to breastfeeding peer support programs, and so we feel this is covered by extending the population ('Who the guideline is for') to cover these groups.
Breastfeeding Network Scotland	8		What tools for clinical review of women are effective during the first 8 weeks after birth (for example, MEOWS)? This should include Unicef BFI feeding assessment and where relevant milk transfer, including infant urine and stools	Thank you for your comment. The exact list of tools will be determined by the committee in the first

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				few meetings, and we will pass on your recommendation that Unicef BEF be amongst those considered.
Breastfeeding Network Scotland	9		We are concerned about early use of progesterone because this is a huge area of controversy amongst lactation experts world wide who see the progesterone only pill / implant injection and combined oral contraception implicated in poor milk supply. It is easy to dismiss this as breastfeeding failure. I believe this should be an area for further research	Thank you for your comment. Although we will not be considering contraception in this guideline, we may consider progesterone as an intervention to recommend against if there are concerns about milk supply. The final content of each question will be determined by the committee during the first few meetings.
Breastfeeding Network Scotland	10		Can "successful" be deleted. Success is for the mother to determine What interventions in the 8-week postnatal period are effective in enabling ~~successful~~ breastfeeding?	Thank you for your comment. We have made the change you suggested.

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			What factors immediately after birth ~~contribute to~~ ~~successful~~ facilitate breastfeeding?	
Breastfeeding Network Scotland	10		What practices encourage breastfeeding? This is about antenatal contact? Would be good to see this section cover removal of marketing materials of infant formula from the NHS and strengthening the UK Law.	Thank you for your comment. Unfortunately NICE guidelines are not empowered to make recommendations about the law and therefore we cannot address your suggestion in the guideline.
Breastfeeding Network Scotland	11		How should ~~successful~~ breast feeding be assessed? Does this mean at community level through data collection in PHE fingertips breastfeeding profiles? Or assessing milk transfer? Which ever way this is important as there is significant variations in practice in terms of breastfeeding support.	Thank you for your comment. A separate question on the assessment of successful breast feeding was not prioritised as we expect these indicators to arise from question 4.5 on interventions which promote successful breastfeeding. The outcomes for this question will be chosen by the multidisciplinary committee as to represent

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				'successful' breastfeeding, based on their professional experience and knowledge of the topic. We will follow the GRADE methodology (which requires identifying critical and important outcomes). This should allow the committee to make more nuanced recommendations on this very important topic, because it will mean assessment can be considered across all feeding questions.
Breastfeeding Network Scotland	11		Change is acceptable as long as this covers maternal concerns such as sore and cracked nipples, engorgement, mastitis, inverted nipples plus raynaulds and thrush are covered. And concerns for the baby: Reluctant feeder, hypoglycaemia Impact of supplementary feeding	Thank you for your comment. The final topics for inclusion will be determined by the committee in the first few meetings. The committee will have at least one breastfeeding expert, and

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			Support should cover local and national eg via the National Breastfeeding Helpline	so this individual will be able to ensure that important topics are covered.
Breastfeeding Network Scotland			Are there interventions to facilitate continued breast feeding when the baby is tongue tied? Nice guidance was written in 2005 and is out of date so ought to be reviewed.	Thank you for your comment. If there is existing NICE guidance in an area (such as IPG 149 on tongue tie) then it will be frequently reviewed to identify if it is suitable for an update. Therefore we will not look at tongue tie in this guideline, because IPG 149 will be part of this review process.
Breastfeeding Network Scotland	p12		This should include any evidence on responsive feeding, portion size and making up feeds to minimise risk of infection.	Thank you for your comment. The questions you ask would be within the scope of the review, although the committee

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			Specialist formula milk and powdered breastmilk fortifier used in neonatal units and making up at temperatures below 70 deg – no independent evidence of safety and babies often vulnerable.	could only make recommendations on it if evidence is uncovered on the topic.
Breastfeeding Network Scotland	12		How should common health problems in the infants be identified and managed? esp constipation and diarrhoea – would be good to flag up that lack of poo in first few weeks in a breastfed baby is a sign of reduced milk transfer – not constipation.	Thank you for your comment. This guideline will not cover management of common health problems in infants because this is extensively covered in existing NICE guidance, for example CG99 (constipation in children & young people) and PH11 (maternal and child nutrition). With regards to problem identification, the guideline will review pre-existing and comprehensive assessment tools that would include multiple questions relating to multiple health problems, such as constipation,

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				diarrhoea or lack of poo. Therefore specific problems are not mentioned in the scope.
Breastfeeding Network Scotland	13		SIDS evidence does need reviewed and co-sleeping should be discussed.	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are

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				effective in preventing sleep difficulties?"
Breastfeeding Network Scotland	Footnote		Specialist care… however inclusion of the recommendation about drugs in breastmilk should be included Use of anaesthetics for any operations during breastfeeding period Procedures carried out on breastfeeding women eg CT MRI VQ scans	Thank you for your comment. Although the final content of each question is decided by the committee in the first few meetings, it is likely that drugs in breastmilk will be covered in 4.4 on the barriers to breastfeeding.
Breastfeeding Network Scotland			Please consider a recommendation for care of the mother if her child is readmitted to hospital	Thank you for your comment. This guideline covers only the routine care of a mother and baby following birth, which would explicitly exclude babies who are readmitted to hospital. Unfortunately this means the committee will be unable to make recommendations on care

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				for the mother if the baby is readmitted.
British Specialist Nutrition Association	21	1-3	1.3.7 makes reference to 'commercial packs'. It is strictly forbidden for infant formula and any advertising relating to infant formula to be contained within these packs. Therefore, the distribution of these packs is not the issue as they WILL NOT and SHOULD NOT contain infant formula or related advertising. It is important that this misinformation is clarified and corrected. This statement is therefore obsolete and should be removed.	Thank you for your comment. The original scope is being completely stood down and new recommendations written from scratch. Therefore the original statement will be removed as requested.
British Specialist Nutrition Association	26	4-7	1.3.42. suggest amendments (underlined) to: 'All parents and carers who plan to give their babies formula feed should be offered appropriate and tailored advice, in a timely manner, on formula feeding to ensure this is undertaken as safely as possible, in order to enhance infant development and health, and fulfil nutritional needs.'	Thank you for your comment. The original scope is being completely stood down and new recommendations written from scratch. Therefore we cannot action your suggestion, as we cannot pre-empt the committee's recommendations.
Centre for Child and	13	Box 7	The draft document states that there is no significant current variation in practice about the risk of bed-sharing and cot death.	Thank you for your comment. In response to

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Adolescent Health, University of Bristol			As part of our current research into unexpected infant deaths we have been interviewing families from almost all areas of England, and have found evidence of very wide variations in advice, policies, information and recommendations given to families by health care practitioners both within individual areas and between areas. We have found little evidence of consistent or evidence-based advice being given – some parents being given advice that is in line with current knowledge, and others being given advice that seems to be based purely on the beliefs of the health care professional and is unrelated to any underlying evidence base. There have been several relevant recent studies that help to elucidate the potential risks of bed-sharing and the circumstance in which the risk is either increased or decreased. It is therefore important that this aspect of postnatal care is reviewed, and appropriate guidance developed.	numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"
CSF Leak Association	18	10	*"What is the optimal content of the postnatal care contacts for women and babies?"* We propose that the content include information for those mothers who have had epidural or spinal anaesthesia about the risk of developing a	That you for your comment. We cannot pre-empt recommendations made by the committee, but CSF leak would be one issue

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			cerebrospinal fluid (CSF) leak which leads to a so-called 'spinal headache', also known as Post Dural Puncture Headache (PDPH). Mothers who have had an epidural have approximately a 1.5% risk of accidental dural puncture with epidural insertion. Of these, approximately half will result in PDPH[1]. The information should also include what to do if a CSF leak is suspected e.g. a short period of bed rest. Awareness of this condition is woefully lacking in all settings but most crucially for this patient group it is also lacking in the primary care setting in which many mothers first report their concerns and symptoms. Mis-diagnosis and diagnostic delay adversely affect treatment outcomes and so we believe it's important to highlight the risk and consequences to all affected patients.[2] The most prominent symptom of a CSF leak, and the subsequent intracranial hypotension, is a headache that can be severe and debilitating and typically has a postural element with symptoms improving after a period of lying down but resuming upon standing up again. The headache is also associated with a range of other symptoms that in themselves can also be debilitating. These symptoms include but are not limited to the following:	upon which the committee could make recommendations.

[1] Choi, P., Galinski, S., Takeuchi, L., Lucas, S., Tamayo, C. and Jadad, A. (2003). PDPH is a common complication of neuraxial blockade in parturients: a meta-analysis of obstetrical studies. *Canadian Journal of Anesthesia/Journal canadien d'anesthésie*, 50(5), pp.460-469.
[2] Safa-Tisseront, V., Thormann, F., Malassiné, P., Henry, M., Riou, B., Coriat, P. and Seebacher, J. (2001). Effectiveness of Epidural Blood Patch in the Management of Post–Dural Puncture Headache. *Anesthesiology*, 95(2), pp.334-339.

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			pain/stiff feeling in the neck, heaviness in the head, sensation of head being pulled downwards, photophobia, interscapular pain, tinnitus, vertigo, dizziness, hypacusia, hyperacusis, blurry vision, double vision, painful eyes, facial numbness, tingling sensations and spams in the spine, back, arms and sometimes legs, cognitive decline (including memory loss and loss of concentration), nausea and vomiting. The impact on the mother is enormous and is in many cases extremely painful, distressing, debilitating and life-changing. She cannot carry out the many and varied acts of daily living required for self-care or caring for her new infant and other children. If left unrecognised and therefore unmanaged or unsuccessfully treated due to diagnostic delay the mother risks emotional attachment problems with her baby and the severe mental and emotional toll resulting in a higher chance of developing mental health problems. Unfortunately mental health issues in CSF leak patients are complicated by the isolating nature of the condition which requires many patients to remain bedbound. If not treated in a timely manner this maternal morbidity can lead to a long term disability which devastates the entire family unit	
CSF Leak Association	18	16	*What tools for clinical review of women are effective during the first 8 weeks after birth (for example MEOWS)?*	Thank you for your comment. We have taken the decision to exclude the

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			The scope document proposes to stand down current guidance on the management of headache and backache in the postpartum period. We believe this to be unhelpful for healthcare professionals looking after this group of patients especially as the current guidance says the following about headaches: "1.2.40 Women who have had epidural or spinal anaesthesia should be advised to report any severe headache, particularly one which occurs while sitting or standing. [2006] " We would prefer the guidance was expanded to include that this most likely indicates a CSF leak and that onward referral to a neurologist or anaesthetist would be appropriate. It is also worth noting that there is some symptom overlap between a headache caused by pre-eclampsia/eclampsia and a headache caused by a CSF leak as they can both present as severe or persistent with nausea or vomiting within 72 hours of birth. It is possible that a mother could suffer from both conditions at the same time and the differential diagnosis could be difficult in the (likely to be small) group. Intracranial hypotension resulting in a postural headache and associated symptoms can present early after birth or a number of weeks later. The reasons for this apparent delay in becoming symptomatic are unknown but research has shown that those with a connective tissue disorder have a	management (though not identification) of common conditions such as CSF leak because stakeholder feedback is that the management of these conditions is not notably variable until the condition because serious enough to require hospitalisation. The comment on being advised to report any headaches could be covered in question 1.5 on the content of postnatal care contacts, although we cannot pre-empt any recommendations made by the committee.

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			higher incidence of experiencing a CSF leak[3]. Current thinking in those medical professionals with an interest in or treating patients with connective tissue disorders is that these patients are routinely mis- or under-diagnosed.[4] Therefore, it is conceivable that neither the mother nor the administering anaesthetist know at the time of anaesthesia if the mother is more likely to develop a CSF leak or if the mother is likely to respond to treatment. Connective tissue disorders are known to involve poor wound healing. Another equally important presentation that primary care practitioners may encounter is the so-called second half of the day headache where the patient is symptom free for a number of hours every day after which symptoms occur which are only relieved by lying down. Regarding backache the current guidance states, "1.2.46 Women experiencing backache in the postnatal period should be managed as in the general population. [2006] "	

[3] Reinstein, E., Pariani, M., Bannykh, S., Rimoin, D. and Schievink, W. (2012). Connective tissue spectrum abnormalities associated with spontaneous cerebrospinal fluid leaks: a prospective study. *European Journal of Human Genetics*, 21(4), pp.386-390.

[4] Gazit, Y., Jacob, G. and Grahame, R. (2016). Ehlers–Danlos Syndrome—Hypermobility Type: A Much Neglected Multisystemic Disorder. *Rambam Maimonides Medical Journal*, 7(4), p.e0034.

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			Back pain is a recognised symptom of a CSF leak and in particular Interscapular pain as a subset of back pain is a typical symptom where no other musculoskeletal issue is at play. We would recommend the expanded guidance above includes a note on the fact that back pain in this patient population may be directed related to the use of epidural or spinal anaesthesia and a CSF leak. Should you decide to omit this guidance, we feel strongly that the tool devised to help perform a clinical review of these patients should include provision for the identification and management of those patients with suspected CSF leak and intracranial hypotension. We thank you for the opportunity to provide our feedback.	
Department of Health			No Comments to add	Thank you for your comment. We are pleased you are satisfied with the scope.
GP Infant Feeding Network	general	general	GPIFN welcomes this update in the interests of providing robust and evidence based standards for those providing care to families in the postnatal period. Recognition of the role of primary care in managing this population group, and frameworks for its delivery are vital to ensure the highest possible quality of care thus securing the best possible outcomes. We hope this	Thank you for your comment. The guideline committee includes a GP and other community members to represent the

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			guideline can underpin the importance of GP involvement for mothers and infants during this period.	role of primary care in the postnatal period.
GP Infant Feeding Network	general	general	We would recommend a shift in the language used around breastfeeding; *effective* rather than *successful* breastfeeding is more objective and avoids unnecessary value judgements being placed on feeding method.	Thank you for your comment. We have made the change you suggested.
GP Infant Feeding Network	2	27	We suggest inclusion of 'commissioners of primary care services' not just 'commissioners of primary postnatal care services' as many contacts with primary care will be unscheduled / non-routine and fall within general primary care provision.	Thank you for your comment. We have changed the wording of this point to "commissioners of primary and secondary postnatal care services, and primary care services".
GP Infant Feeding Network	3	23	Will the guideline look to redefine this timeframe? We would express concern if the timeframe was to become shorter.	Thank you for your comment. There is no intention to redefine this timeframe, and we see that the wording you highlight might be taken as ambiguous with respect to this. Consequently we have changed the wording to "Women and babies from

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				the birth of the baby until the end of the postnatal period which, for the purpose of this guideline, is defined as 8 weeks after the birth."
GP Infant Feeding Network	4	14-18	We recommend that particular care is taken to outline to users of the guideline that use of medications in lactating women is an exceptional case, whereby the summary of product characteristics does not always provide helpful and practical information and in some cases, when followed exactly, can do harm to a breastfeeding relationship. Specialist services e.g. the NHS commissioned UK Drugs in Lactation Advisory Service, and Breastfeeding Network Drugs in Breastmilk service should be signposted to.	Thank you for your comment. Breastfeeding would be an example of an exceptional situation as allowed for by the disclaimer in the scope, and so the committee would be able to consider evidence on drugs for use during breastfeeding as long as there is evidence supporting their use (as with any other intervention).
GP Infant Feeding Network	18	7-9	Whilst we acknowledge that this guideline will not cover perinatal mental health, we would hope to ensure that this review question takes into account perinatal mental health morbidity and mortality before making a recommendation (i.e. the traditional GP 6-8 week postnatal check is widely	Thank you for your comment. While we cannot pre-empt committee recommendations, it is

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			used as an opportunity for identifying thus far undiagnosed mental health problems). It is worth noting, for example, the often significant overlap between perinatal mental health pathology and feeding issues; fully removing the mental health aspect from the review question may falsely reduce the importance of this contact. We recognise that professional competencies fall outside of NICE guidelines, but defining the level of experience / qualification / profession of the healthcare professional carrying out this review would be welcome.	possible for the committee to determine that the post-natal check could be used to assess maternal mental health and therefore cross reference into the appropriate guideline.
GP Infant Feeding Network	18	25-26	Defining the level of experience / qualification / profession of the healthcare professional carrying out this review would be welcome, for example ensuring the review question includes establishing what level of training in weighing and measuring of babies is needed and what practical resources (e.g. growth charts, access to weighing facilities) are required to deliver this.	Thank you for your comment. Unfortunately NICE guidelines are not allowed to consider level of qualification, as this is the remit of professional bodies. Consequently we will not be able to action any part of your comment other than the profession of the person carrying out the review (if there is evidence on this topic).
GP Infant Feeding Network	18	24-30	We highlight that there is no review question asking 'when should a comprehensive, routine assessment of the infant at the end of the postnatal period occur (for example at 6 weeks, 8 weeks or not at all)?' as part of	Thank you for you comment. The exact scope of each review question is

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			section 3 and would recommend inclusion of this, or assurance that the scope of question 3.1 will include this.	determined by the committee in the first few meetings, but the question was written to explicitly include timing of a comprehensive postnatal infant assessment if evidence is found on this topic.
GP Infant Feeding Network	18	27	Specific guidance on recommendations for safe sleep arrangements would be welcome within the scope of this review question (we disagree with the earlier comment in the table that there is no significant variation in practice on the issue of co-sleeping risk).	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant

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				sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"
GP Infant Feeding Network	18	27	We suggest that the scope of this review question is too narrow; adverse outcomes are wider than just hospital admission. For example, a missed heart murmur or dislocated hip could lead to a significant adverse outcome, but identification of them at a routine neonatal review would not necessarily prompt an immediate hospital admission.	Thank you for your comment. After discussion we have agreed to reword the question to "What signs and symptoms (alone or in combination) in babies are associated with serious illness or mortality?"
GP Infant Feeding Network	18	32-33	We would welcome assurance that this review question will capture when and where this information should be delivered as well as its content.	Thank you for your comment. While we cannot pre-empt recommendations written by the committee, the question was explicitly written with the intent of making recommendations about timing and place of information delivery, and

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				therefore recommendations can be made on these topics if evidence is uncovered supporting such recommendations.
GP Infant Feeding Network	19	1-4	We assume that question 4.3 pertains to bottle feeding of expressed breastmilk given that question 4.2 is specific to formula feeding. Could this question therefore be better defined as such?	Thank you for your comment. Question 4.3 is intended to deal with issues common to both expressed breast milk and formula feeding, for example how to sterilise a bottle.
GP Infant Feeding Network	19	5-8	It would be of benefit to GPs managing this population if these review questions specifically address the management of common breastfeeding problems that are not covered by other NICE guidelines (e.g.mastitis, thrush)	Thank you for your comment. Depending on the evidence the committee uncovers, common breastfeeding problems may be a significant barrier to initiating and sustaining breastfeeding (question 4.4). Consequently the committee may make recommendations on

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				overcoming these barriers, if the evidence supports such recommendations.
GP Infant Feeding Network	18 & 19	31-33 & 1-8	We welcome a comprehensive review of the evidence for infant feeding management. We hope to see recommendations on minimum expected standards for healthcare providers to facilitate the best possible protection, promotion and support of breastfeeding as part of this.	Thank you for your comment. We are pleased you support our intention to look at the evidence on infant feeding management. Unfortunately we cannot pre-empt recommendations the committee might make on this topic, as it will depend on what evidence they uncover during development.
Infant Sleep Information Source	13	What is the risk of co-sleeping in relation to sudden infant death syndrome (SIDS)?	The draft scope proposes to 'stand down' the current guidance on SIDS/co-sleeping on the basis that 'There is no significant variation in practice, so recommendations from NICE are not needed in this area.' **We strongly urge NICE to retain this guidance**. We are aware of (and show below) significant variation in practice around this topic; retention of **this recommendation from NICE is crucial to ensure parents are provided**	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death

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			with appropriate information and supported to make informed choices on SIDS and co-sleeping. Parents in England and Wales frequently tell us that they receive conflicting information from health professionals around co-sleeping and SIDS, and often feel compelled to hide their co-sleeping arrangements from health professionals for fear of being reprimanded. This does not foster information sharing or informed choice. Health Professionals around the country tell us that Trusts 'do not allow' staff to discuss SIDS/co-sleeping information with parents, or that Trusts have policies that require staff to advise all parents to never co-sleep with their baby under any circumstances. When, at training workshops, we share the existing NICE guidance emphasising empowering families to make informed choices, Health Professionals state they feel they have been given permission to have conversations with parents on this topic. **To lose this guidance that empowers staff and parents to discuss this important issue would be a backwards step.** Examples of the variations in practice are documented in feedback comments following our recent workshops (2015-17) e.g. : HCP Wales: "Info often given by many is outdated - choice & individualised care most important"; HCP Wales: "We must change Trust practice & discuss reducing risk of bed-sharing rather than say "don't bedshare""; HCP London "We must ensure Trusts implement these NICE guidelines, which they currently don't"; Student MW Newcastle: "We must stop MWs saying 'no	and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			bed-sharing' for all parents". These comments are echoed by repeated cohorts of Student Health Visitors we provide training to, who report wide variation in their training on SIDS and co-sleeping. When we recently explored the information new mothers receive about co-sleeping and SIDS we found widespread lack of awareness around the dangers of sofa-sharing; smokers/drug-users did not understand the risks associated with SIDS and bed-sharing; mothers felt that discussions with HCPs about safe bed-sharing practices were absent with the exception of rare conversations with well-informed HCPs. This month we asked the users of our Infant Sleep Info website (www.isisonline.org.uk) for comments on whether the NICE recommendations on SIDS and co-sleeping are still needed, and whether significant variations in practice exist. We received 106 responses from mothers and health professionals around the country again documenting wide variations in practice and the important role of this guidance: **Health Professionals' comments about NICE guidance** ***NICE Guidance helps us to inform parents****. Dread to think if not in guidelines what will be said! So many parents do co-sleep... What are we to advise without guidance (as it won't protect us legally - anything we advise). I can see* ***without guidance we will not advise at all around co-sleeping****.* *I am a community IFC in the North West. Having the NICE guidelines along with UNICEF/Lullaby Trust Caring for your baby at night and our local Pan*	

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			Cheshire guidelines have finally meant I am winning the battle to empower HV staff to have the confidence to discuss bed sharing with all parents. ***It is not embedded enough in practice yet to not have NICE's guidelines*** *and I fear it could mean a backward step. These conversations can save babies lives, as we know with co-sleeping 90% occur where there are risks factors and as a HP we can potentially prevent an unnecessary deaths, it saddens me to think that HP's are frightened to discuss this.* *Sussex NHS Trust: Yes, this part of NICE guidance is definitely needed. It really supports practitioners in working with families and gives them clear guidance. (Isn't that what NICE is supposed to do?!)* ***There is variation in practice - as this thread shows- removing these statements will open up parents to even more conflicting and less than optimum advice.*** *Definitely needed to reduce inconsistencies and for health professionals to feel confident about providing information.* ***In many cases NICE is the basis of trust guidelines so I would be worried about it being removed*** *(I'm a HV).* *Their statement is the opposite of true. As an IBCLC and breastfeeding counsellor I speak to families locally and also on the national helplines. I regularly speak to parents who have been told they are not 'allowed to bed share' or it is considered dangerous or they 'should stop'. I also speak to families who are shown your site and UNICEF resources.* ***The variation in guidance could not be greater****. It feels like an even split between the 'not allowed' group and those given support. I also speak to breastfeeding*	

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			volunteers who are told in their local areas that are not supposed to mention co-sleeping. *YES IT IS VITAL!* ***The NICE guidance is completely needed in this area! Guidance and information on safe sleeping and especially around co-sleeping is where there is the greatest inconsistency in support and information given to families****. It seems to be mainly based on the personal opinion of the HV, GP or midwife. I work with new mothers and every mother is told something different depending on who they are talking to. But the headline always seems to be 'do not co-sleep' it's dangerous.* *I'm a HV, currently an infant Feeding coordinator on a maternity unit. It is *vital* that we continue to include the section around ensuring we have conversations on co sleeping and associated risk factors.* ***There is huge variation around the info shared and this is with the guidance in place, if it is removed I fear *no* conversation will be had and we will revert back to an era when it wasn't discussed and blanket 'bans' were the go to advice****. There's still a lot of practice that hasn't changed with very few (in my experience) HCPs aware of the change to NICE guidance in 2014. If NICE were to change it on the basis of "lack of wide variation" in this area then I'd love to see their evidence.* *As a midwife I think* ***it is essential that safe sleeping guidance is included in Postnatal Care****. I always teach about safe co-sleeping. If this is removed then it may not be deemed necessary to discuss the important if*	

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			not falling asleep on sofa, smoking, alcohol, drugs inc prescription drugs. Parents need to be informed of safe sleep guidance. **Health Professionals' comments about variation in practice** *Where I currently work as a health visitor* ***you have some who say not to co sleep at all and some who discuss making an informed decision and give the info on how to do it safely.*** *I've even heard a midwife who wanted to make a MASH referral because a mother was bed-sharing and chose not to stop.* *I am a health visitor, I trained in London. Low sids rates, high breast feeding rates. Actively encouraged to discuss/recommend co sleeping/bed sharing safely. Worked in Essex, higher sids rates, lower breast feeding rates. Actively encouraged to hand out 3 different leaflets/pieces of info saying co sleeping/bed sharing is dangerous and encourage every family to never co sleep/bed share. I hear/see this from colleagues all over the Country.* ***It depends on the whim of the Trust you work for as to what you are allowed to advise. It is dangerous.*** *Paediatrician: I don't remember any training or teaching in my postgraduate career on normal infant sleep. Before having my own children I would have strongly recommended not bedsharing at all. My personal experience of parenting triggered me to revisit the evidence and changed my understanding considerably. There is still nothing on normal infant sleep and safe bedsharing practice in postgraduate training in Paediatrics as far as I'm aware.*	

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			In our current trust we are encouraged as public health nurses to deter bed sharing and promote infants sleeping in their own bed space but the same room for the first 6 months. I as a breastfeeding mother myself are therefore more open to talking about safe bed sharing to parents but a lot of my colleagues aren't. *It's so much safer to talk about it! I'm a bf peer supporter & we talk to lots of mums who are trying to keep themselves awake sat up feeding baby. Much safer to bed-share safely than fall asleep accidentally with baby. It would be better if hv could hand out this info.* ***Variation in practice is still widely spread**. I have witnessed it on many occasions … working alongside health visitors and midwifes. I even had a complaint made against me from a MSW for talking through safe sleep messages with a mum who kept nodding off with her baby in her arms.* **Parents' comments about NICE guidance** ***Critically still needed. Mostly this guidance is ignored**, Baby Friendly assessment and every mother in the UK can surely tell them that? It will take a generation at least to change the prevailing "you will kill your baby of you co sleep" message, despite all evidence.* ***Cosleeping & SIDS absolutely should remain in the NICE guidelines and all HCP's should be able to share the facts in an unbiased way.** Despite being involved with the local maternity community and being well versed in the guidelines, I was still told off by HV's with both children and given questionable advice. The idea of there being "no significant variation*	

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			in practice" is ridiculous because HCP's STILL aren't being trained appropriately in this subject. ***HPs need to know that they CAN talk about it. Having the statement there is hugely important**. If the few HPs who do talk about it are told they can not, or are unsure if they can. Then the information out there will be even more limited than it is currently.* *This is an absolute must. I remember post natal in an absolute daze googling about safe bedsharing. My HV told me sternly on no account should I bed share. That she had seen babies die from this, and that doing so was tantamount to "murder". Her words.* ***I think having the NICE guidelines gives practitioners confidence in their advice and given the prevalence of co-sleeping this discussion is essential**. I don't understand the reputed rational for removing it.* *When I had my first child 3 years ago the HV 'discussed' co-sleeping with me in a manner that basically tried to put me off. With my newborn this time the HV (a different one) has been much more sensible about it and talked about making an informed choice.* *I think it is needed and needs HV's to be educated as **it varies so much not just by area but also with in trusts.***	

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			The guidance is definitely needed. There is so much stigma about co-sleeping. It becomes something you are scared to admit to for fear of being deemed irresponsible. *Oh, god, yes! I run a parent support group (900 members strong) and* ***we hear, almost weekly, how HP's are advising against cosleeping and not giving information on safe cosleeping!*** *Guidance is definitely needed in this area.* **Parents' experiences of HPs not following NICE guidance** *In Calderdale, West yorkshire, I was leadingly told that 'we need to discuss bedsharing with you. If you bedshare, we will refer you to children's services. Do you bedshare?'* *Warwickshire Health Visiting Team (with the exception of the community nursery nurse) strongly discourages cosleeping and anything other than cot sleeping* *Northern Ireland: Received no advice, support or recommendations re cosleeping or available resources from NHS staff… Was never even a conversations around cosleeping other than it being mentioned briefly it antenatal classes that you shouldn't do it* *HV in Belfast shook her head and said don't tell me anymore...when I started to talk about bringing my baby into bed with me. She said that she wasn't allowed to discuss co-sleeping …*	

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			I was planning to co-sleep with my son and I had read everything the internet had to offer on the subject. In a nutshell, I told my HV this and my HV refused to engage with me on the subject. I asked her repeatedly for the latest advice on how to safely co-sleep and all she had to say was 'don't do it.' I did it anyway. **The above reflects only one quarter of the comments received. Our experience of engaging with new parents and the Health Professionals who work with them is that much variation in practice exists around the discussion of SIDS and co-sleeping in the early postnatal period, and the existence of current NICE guidance is vital in supporting the provision of accurate information, and reminds NHS staff and Trusts that providing such information is a requirement of their role.**	
Johnson & Johnson	**12**	Lines not numbered in table **Section:** 4. Maintaining infant health **Sub-section:** How should common health problems in	Johnson & Johnson Ltd. welcomes the decision to stand down the original recommendations on infant skincare during the post-natal period. Since the original Guideline was developed, new evidence-based information on suitable alternatives to water only cleansing has become available. In addition, Johnson & Johnson Ltd. is aware that other Nursing and Midwifery organizations have developed or are using more current resources to guide and inform their practice recommendations to care for infant skin around the world. Information that Johnson & Johnson Ltd. will be happy to share at the appropriate time during the guideline update process.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, it is not expected that information on basic cleaning and care of a baby's skin will be covered by a review.

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		the infants be identified and managed? (skin)	Also, Johnson & Johnson Ltd. is aware that The Royal College of Midwifes (RCM) in the UK will be publishing Skincare Guidance in early 2018. In light of this we hope that NICE will conclude that information on basic cleansing and care of baby's skin is either not required in the fully updated NICE Guideline on Post-natal care or that the NICE guidance will mirror that of the RCM.	
Johnson & Johnson Ltd.		General	Johnson & Johnson Ltd. welcomes the decision to undertake a full update of the guideline on Postnatal care up to 8 weeks after birth and looks forward to engaging fully in the guideline update process.	Thank you for your comment and interest in this guideline.
King's College London	1	22 - 26	Evidence from large studies in the UK and countries with similar maternity systems (ie Australia), and more recent surveys of women's experiences of their maternity care (ie CQC) suggest that the postnatal period is not uncomplicated for most women and babies. Many women experience problems with their own recovery and/or with an aspect of infant care, such as breastfeeding, as described on p2 of the scoping document. Nor should problems be perceived as more relevant to women giving birth for the first time.	Thank you for your comment. We have attempted to draw a distinction between a postnatal period which is routine (with or without complications) and a postnatal period which is outside the routine for either mother or baby. This will normally map onto whether hospital readmission is required, but the committee will determine exactly where

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				the distinction lies within the first few meetings. There is no assumption that problems are more relevant to first-time mothers, but the scope does leave room to make different recommendations for first-time mothers and mothers who have already given birth if the evidence supports such differentiated recommendations.
King's College London	2	25	There is no evidence that 8 weeks is the optimal time to end maternity care. This timing was previously related to GP payment for services provided, which is no longer the case. NICE should consider how care can best meet women's individual health needs, with some women potentially benefitting from longer contact.	Thank you for your comment. The guideline relates to interventions and decisions which can be made in the first 8 weeks after birth to improve women's health. Consequently a decision taken within the first 8 weeks to delay the

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				comprehensive, routine assessment of the woman until (for example) week 10 would be within the scope of the guideline. While we cannot pre-empt committee recommendations, if the committee uncover evidence that such a delay would better meet some women's needs then they would not be prevented from making the recommendation.
King's College London	5	TABLE	Re: What information needs to be communicated between healthcare professionals at transfer of care? This also needs to consider system level information, given the number of women transferred home from hospital who are 'out of area' for community contacts. This is a real issue in London, with important information often not provided to teams contacting women for the first time as their pregnancy/birth and immediate postnatal care were provided at another	Thank you for your comment. The final content of the review questions is finalised by the committee in the first few meetings, and therefore the committee may be able to make recommendations on this topic if evidence is

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			NHS Trust. It should also consider how communication between healthcare professionals at hospital and community settings can be best carried out, and what needs to be in place to ensure optimal communication between healthcare professionals across hospital and community settings.	uncovered supporting those recommendations.
King's College London	6	TABLE	Re: Maternal health and wellbeing core information and advice. Rather than use 'including discharge' 'including transfer home' may be preferable, to stress that women require ongoing contacts.	Thank you for your comment. We have made the change you suggested.
King's College London	6	TABLE	Re statement here and elsewhere in the table: *There is no significant variation in practice.* It is unclear what this refers to, as we have no evidence and potentially there could be huge variation in 'practice'. It is unclear if this statement refers to 'practice' per se, or to signs and symptoms of PPH and other major maternal morbidities, and clarification is sought.	Thank you for your comment. In response to your and other stakeholder comments we agree this phrasing is unclear and have added a question on assessment of possible PPH.
King's College London	6	TABLE	*Re: New review question: How should pre-eclampsia be assessed in women who have had pregnancy induced hypertension or pre-eclampsia?*	Thank you for your comment. The original intent of this question was to focus only on women who develop postnatal pre-

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			It is very important to reflect the fact that some women may develop postnatal pre-eclampsia/eclampsia who have not had any pregnancy symptoms. We suggest this question is revised.	eclampsia/eclampsia who have not had any pregnancy symptoms, but following feedback we have determined that this condition is too rare to support an evidence base upon which the committee could make recommendations. Consequently this question has been removed from the final draft of the scope.
King's College London	6	TABLE	*Re: No evidence review: stand down original recommendations. This is covered by the NICE guideline on venous thromboembolism, which will be cross-referred to in the update.* *Re: No evidence review: stand down original recommendations. This is covered by the NICE guideline on antenatal and postnatal mental health, which will be cross-referred to in the update.* It is extremely important that the signs and symptoms of thrombosis and other major physical and psychological morbidities are included in this	Thank you for your comment. NICE process is only to cross-refer where other guidelines contain relevant recommendations, not duplicate those recommendations. This is because it allows these guidelines to be updated independently of each other, so that NICE can

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			guideline. Women/clinicians will only refer to specific guidance once a condition has been identified. Knowing what to look out for is key to reducing major morbidity among postnatal women.	respond rapidly to new developments in the field.
King's College London	7	TABLE	Re: How should common health problems be identified and managed? (perineal pain) Please clarify what is meant by *'there is no significant variation in practice, so recommendations from NICE are not needed in this area'.* We consider that NHS staff need guidance not only on how to *assess* perineal pain (and its cause) but also *manage* in terms of advising women on pain relief and signs/symptoms of infection	Thank you for your comment. We have taken the decision to exclude the management (though not identification) of common conditions such as perineal pain because stakeholder feedback is that the management of these conditions is not notably variable until the condition because serious enough to require hospitalisation, whereupon the condition requires specialist management outside the scope of this guideline. While we cannot pre-empt recommendations made by the committee, signs and

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				symptoms of infection are not excluded from consideration of assessment of perineal pain and so the committee may wish to make recommendations on this topic if the evidence supports this.
King's College London	7	TABLE	It is unclear if evidence is available to demonstrate that variations in practice re management of dyspareunia have decreased since 2006. Clarification welcomed, especially re *New review question: What tools for clinical review of women are effective during the first 8 weeks after birth (for example, MEOWS)?* included against this health problem. MEOWS have not been validated in pregnant/postnatal women. Our studies show a wide range of parameters used and need to ensure action 'triggered' by a MEOWS is appropriate and timely. Furthermore, MEOWS have not been tested in community settings, and are inappropriate to detect much maternal morbidity (severe and more common). We suggest that for postnatal women, MEOWS should only be considered for those readmitted	Thank you for your comment. The reference to MEOWS was intended to be only an example, but we have removed the reference to prevent confusion. The actual tools considered in the review will be determined by the committee in the first few meetings.

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			to hospital which is outside of the remit of the guideline (and even then, we do not know if MEOWS are of benefit). REFS: Bick D, Wee MK, Isaacs R, Smith GB, Furuta M, Sandall J, Beake S (2014). A national survey of heads of midwifery services of uptake, barriers and benefits of use of obstetric early warning scores (EWS) by midwives. Midwifery; 30(11):1140-6 Isaacs RA, Wee MYK, Bick DE et al (2014). A national survey of obstetric early warning systems in the United Kingdom: the current picture five years on. Anaesthesia. 2014 Jul;69(7):687-92. Smith G, Isaacs R, Andrews L, Bick DE et al, Vital signs and other observations used to detect deterioration in pregnant women: an analysis of vital sign charts in consultant-led maternity units. Int J Obstetric Anaesthesia. 2017 May;30:44-51 Mackintosh N, Watson K, Rance S, Sandall J. Value of a modified early obstetric warning system (MEOWS) in managing maternal complications in	

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			the peripartum period: an ethnographic study. BMJ Qual Saf. 2014 Jan;23(1):26-34. Rance S, McCourt C, Rayment J et al. Women's safety alerts in maternity care: is speaking up enough? BMJ Qual Saf. 2013 Apr;22(4):348-55 REF:	
King's College London			Use of checklists/tools to identify postnatal health problems is likely to lead NHS staff to 'miss' other problems and not ask appropriate questions of women/partners/family members, leading to use of 'tick box' checklists which evidence shows do not identify maternal morbidity and may prevent women from 'speaking up' REFS: MacArthur C, Winter H, Bick D et al (2002). Effects of redesigned community postnatal care on women's health 4 months after birth: a cluster randomised controlled trial. The Lancet; 359: 378 – 385.	Thank you for your comment. We anticipate questions 2.2 and 1.5 being reviewed consecutively, so that if there are clinical tools which can address postnatal concerns about dyspareunia, constipation, haemorrhoid, faecal incontinence and urinary symptoms then these can be recommended as the optimal content of the postnatal care contact. If

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			Bick D, Murrells T, Rose V et al (2012). Improving postnatal outcomes using continuous quality improvement: a pre and post intervention study in one English maternity unit. BMC Pregnancy and Childbirth. Jun 6; 12(1):41. Mackintosh N, Rance S, Carter W, Sandall J. Working for patient safety: a qualitative study of women's help-seeking during acute perinatal events. BMC Pregnancy Childbirth. 2017 Jul 17;17(1):232.	there are no such tools, or existing tools do not capture concerns adequately, the committee will be able to use consensus methods to address the topic in more detail in question 1.5. This should prevent a problem where important questions are not asked because they are not included in a checklist.
King's College London	10	TABLE	Re new review question: *When should a comprehensive, routine assessment of the woman at the end of the postnatal period occur (for example at 6 weeks, 8 weeks or not at all)?* Could this question also consider 'tailored to the individual need of the woman'?	Thank you for your comment. After discussion, we believe the proposed change pre-empts the findings of the evidence review, as it is possible (although admittedly unlikely) that evidence clearly shows tailoring a review is harmful to women in some way. Consequently we will not make the

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				proposed change, and the committee are free to recommend a tailored or standardised assessment as the evidence suggests.
King's College London	11	TABLE	Re new review question: *What information and support on breastfeeding should be provided to parents?* It is important that this question also considers a woman's partner and family members in supporting infant feeding. Cultural beliefs and traditions that influence women's breastfeeding behaviours and what health care professionals can do to optimise care for and health of mothers and babies also need to be addressed (e.g. some cultures only feed babies up to 6 weeks)	Thank you for your comment. While we cannot pre-empt committee recommendations, it is likely that the committee will also want to consider these issues in their deliberations, depending on the evidence that they uncover.
King's College London	12	TABLE	*New review question: What tools for clinical review of babies are effective during the first 8 weeks of life?* This relates to concerns above re relying on tools to complete clinical review and not asking women/partners/family members about any concerns or other problems they may have noted in their babies. It is	Thank you for your comment. We have rewritten the question completely to read "What signs and symptoms (alone or in combination) in babies are associated with serious illness or mortality?"

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			unlikely that one tool would capture the range of problems an infant may develop. *New review question: What are the signs and symptoms of babies that lead to hospital admission?* This question does not make sense and should be revised. There is also an assumption that babies would need to go to hospital	
King's College London	13	TABLE	Recommendation re incidence, risk and prevention of accidents, co-sleeping and tools to identify the child at risk of abuse: It is unclear what 'There is no significant variation in practice' means – is this based on recent evidence?	Thank you for your comment. We had significantly underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and

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				"What interventions are effective in preventing sleep difficulties?"
King's College London	General		There is no mention of planning of postnatal care. In the current guideline, it is recommended that planning for postnatal care should commence around 28 weeks gestation. One reason for the poor quality of current care and fragmentation of care is the lack of any planning, meaning that all women being transferred from their place of birth potentially receive the same number of contacts and content of care, regardless of any pre-existing or pregnancy related health or social needs which should be taken into consideration.	Thank you for your comment. The planning of postnatal care is outside the scope of this guideline, as ideally it would take place antenatally and this guideline only considers interventions made postnatally.
King's College London	General		Many women experience co-morbidities – physical, psychological, and sometimes complex social needs, which need to be accounted for when planning and assessing content and duration of of postnatal contacts.	Thank you for your comment. The reason for removing the question on the number of postnatal contacts is exactly as you highlight - that many women experience physical and psychological co-morbidities, and sometimes have complex social needs. Therefore a question on the

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				number of contacts is not as helpful as a careful consideration of the content (and therefore duration) of contacts. We would expect, therefore, question 1.5 would be able to contain the information you request, depending on the evidence the committee uncovers.
King's College London	General		As the postnatal period is viewed as a 'missed opportunity' to support maternal health over the life course and improve outcomes of any subsequent pregnancies (Bick et al 2015, CMO report 'Health of the 51%), it is important that this guideline also considers interventions to promote healthy lifestyles (e.g. smoking, alcohol, healthy eating and weight management) postnatally. There is no mention of these aspects of maternal health in the scope.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, question 1.5 and 2.1 on the content of postnatal care contacts and information on self-care (respectively) may be an opportunity for the committee to consider the evidence on health promotion and make recommendations accordingly.

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Midwifeexpert.com	General	General	Early transfer home after birth is often guided by bed occupancy not individual care – re admission rates are rising – breast feeding rates are not reaching UNICEF baby friendly levels – general advice on health and wellbeing can be sporadic due to number of visits an staffing levels and amount paid by commissioners. Use of trained support workers in low risk post natal care should be supported in light of number of midwives available and increase in antenatal screening.	Thank you for your comment. Question 1.1 addresses the length of postpartum stay, and if there is any evidence on models of care that allow a more appropriate length of postpartum stay the committee will be able to consider this in the drafting of their recommendations.
Midwifeexpert.com	General	General	Use of complementary therapies in post natal care by a qualified practitioner should be encouraged for health and mental wellbeing – relaxation techniques use of lavender for perineal healing.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, question 2.1 on advice regarding self-care would be an appropriate question with which the committee could consider evidence on complementary therapies.

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Midwifeexpert.com	General	General	Women should be made aware that pre eclampsia is often diagnosed post natally in 4% women	Thank you for your comment. While we cannot pre-empt recommendations written by the committee, this topic will be covered in the question on information women receive on self-care and if the evidence supports making women aware of this fact then the committee will be able to draft a recommendation on it.
Midwifeexpert.com	General	General	Extending post natal care could utilise community centres in towns/ church halls rather than at home – best use of trained staff/ community/family support/ health and well being for mothers and families. Using social service support jointly.	Thank you for your comment. We agree that the phrase 'home setting' was too limited and have changed it throughout the scope to 'community care', which may encompass the additional settings you list in your comment.
NCT	General	General	We are concerned that this guideline will not include any evidence reviews on mental health. We appreciate that maternal mental health is covered by	Thank you for your comment. Question 1.5 will

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			Guideline CG192, but feel that this review should address the question "when and how should HCPs ask about mental wellbeing in order to determine whether assessment under Guideline CG192 is needed?" and we would like to bring evidence on this question.	address the optimal content of postnatal care contacts, which may include discussions of mental health issues. If this was the case the committee would cross-refer into the appropriate guideline.
NCT	3	3-4	This guideline will also be relevant to organisations and volunteer groups providing breastfeeding, bottle feeding and formula feeding peer support. Some of these will be delivering a commissioned service.	Thank you for your comment regarding the range of organisations and groups that are involved in infant feeding.
NCT	17	30	The proposed review question "When should the first contact be made following discharge to the home setting?" seems very narrow to address the issue of planning the content and delivery of care. We are also very concerned that the question of optimal number of postnatal contacts has been dropped and feel this will lead to a lack of care. The feedback we hear from women is that very often postnatal contacts are minimal due to pressure on services, and they don't feel able to ask for more time with their midwife postnatally. Many women, especially first time mothers and those with mental health vulnerabilities, benefit from a guaranteed, booked contact. We feel that, given the current squeeze on all NHS services, the	Thank you for your comment. We recognise that the number of postnatal care contacts is an important issue to women. After discussing internally, we have decided not to amend the scope; the clinically important aspects of postnatal care are that a

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			only way to ensure women get the care they need is to specify contacts whether they be with midwives, GPs or maternity support workers.	certain set of actions and checks are undertaken, and that the woman feels supported and confident with the baby (especially if she is a first-time mother). Since there are many models of care that can provide this, specifying a particular number of contacts would limit the flexibility of healthcare providers to respond to local need. In addition, there is a worry that specifying a particular minimum number of contacts would become the de facto maximum number of contacts. The committee will be made aware of the complexity of the issue around this question before drafting the evidence review protocol.

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NCT	18	1-2	Surely this depends on the mode of birth? We would like to see this question expanded upon.	Thank you for your comment. The question in this scope document specifies the general area that we will be looking at during guideline development. When developing the systematic review protocol (which will guide the evidence review process), the committee will consider your comment in defining subgroups for stratified analysis. Please also note that there is already some guidance on length of stay after a caesarean section in the NICE Clinical Guideline CG132 on caesarean section, which will be taken into account when drafting the review protocols:

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				"1.6.7.1 Length of hospital stay is likely to be longer after a CS (an average of 3–4 days) than after a vaginal birth (average 1–2 days). However, women who are recovering well, are apyrexial and do not have complications following CS should be offered early discharge (after 24 hours) from hospital and follow-up at home, because this is not associated with more infant or maternal readmissions. [2004]"; we are therefore unable to make recommendations on women who are recovering well, are apyrexial and do not have complications following CS.
NCT	18	3-4	We suggest expanding this review question to include transfer from midwifery care to both GP and Health Visitor. Limiting it to hospital care	Thank you for your comment. The question has

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			excludes women who give birth at home, and also may lead to an ineffective handover between community midwife and health visitor. In addition, what if a mother and/ or her baby is readmitted to hospital with birth or feeding related complications?	been changed to: "What information needs to be communicated between healthcare professionals at transfer of care from place of birth to community care?". This should make it clearer that there are many settings in which women give birth other than the hospital, and not all women are transferred straight home. Management upon readmission to hospital is not covered by this guideline. This guideline only covers routine care, and a readmission to hospital for either mother or baby would therefore be outside the scope of the guideline.

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NCT	18	7-9	We welcome this review question and would like to see added "and who should conduct this check?"	Thank you for your comment. It is anticipated that the committee will make recommendations on this topic if there is evidence to support them.
NCT	18	10-11	It is important that this question addresses the issue of separate postnatal appointments for mothers and their babies. Research shows that very often there is little or no attention given to mothers' physical or emotional health as all the appointment time is devoted to checking their baby. We would also like to see consideration given to the most appropriate health professional to conduct each assessment – possibly midwives for the mother and health visitors for the baby.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, it is likely that they will want to make recommendations on the optimal format of these appointments. If the committee uncovers any evidence on the most appropriate healthcare professional to carry out the check then the committee will be able to consider this as part of their deliberations.

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NCT	18	16-17	It is important that this question is expanded to "What tools for clinical review **of the physical and emotional health** of women are effective during the first 8 weeks after birth?" Research suggests that guidance is needed on how HCPs should conduct questioning in postnatal checks to elicit a full and open response on wellbeing, in order to establish whether whether assessment is appropriate using the methods specified in Guideline CG192 ie. the GAD or Whoolley questions	Thank you for your comment. Unfortunately we cannot revisit recommendations made in CG192 but we will pass your comment on to the NICE clinical updates team in order that they can be considered the next time CG192 is updated.
NCT	18	18-23	We would like to see these questions expanded to include the appropriate health professional to conduct the assessment.	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, if there is evidence on this topic the intention of the question is that it would be appropriate to comment on this.
NCT	18	12-23	We are concerned that there is no mention of assessing the likelihood of domestic violence.	Thank you for your comment. NICE have existing guidance on domestic violence and

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				abuse (PH50) which covers the postnatal period. We would expect to cross-refer into this guideline where appropriate, for example as part of the postnatal check.
NCT	18-19	32-8	It would benefit both mothers and babies if the section on 'Planning and Management of Babies Feeding' included reviewing any research on assessing successful breastfeeding, for example the optimum time points at which to review and the handover information necessary for providing appropriate support.	Thank you for your comment. A separate question on the assessment of successful breast feeding was not prioritised as we expect these indicators to arise from question 4.5 on interventions which promote successful breastfeeding. The outcomes for this question will be chosen by the multidisciplinary committee as to represent 'successful' breastfeeding, based on their professional experience and knowledge of the topic. We will follow the GRADE methodology

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				(which requires identifying critical and important outcomes). This should allow the committee to make more nuanced recommendations on this very important topic, because it will mean assessment can be considered across all feeding questions.
NCT	General	General	We would like to see some reference in this scope to encouraging attachment and bonding with babies, for both mothers and their partners. This is not just about mental health but about encouraging and supporting the development of a new family. Time frames for bonding can vary significantly and yet all be entirely normal. Information for both health professionals and parents would be very useful.	Thank you for your comment. Attachment / bonding will be an outcome for all review questions where it is appropriate, and so therefore if evidence is found on this topic the committee will be able to make recommendations on improving attachment / bonding.

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NCT	19	7-8	Will this question cover interventions which are provided by third sector organisations and volunteers, such as peer support schemes? Will this question also cover a review of the evidence on co-sleeping? This practice is commonly held to be associated with successful breastfeeding.	Thank you for your comment. If the committee uncover any evidence on the contribution of third sector organisations and volunteers then they will be able to make recommendations on this topic. This question will not cover a review on co-sleeping. Instead, in view of the importance of the topic, a new question will be added on advice about sleeping.
NHS England	2	6-9	Could use the reference and evidence from the newly released national maternity and perinatal audit to substantiate.	Thank you for your comment. Introductions to scopes are traditionally not referenced in NICE guidelines, however we will take this publication into account when writing

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				introductions to systematic reviews in the guideline.
NHS England	2	10	Clarify type of survey eg "local" "national"	Thank you for your comment. The statement is based on the survey carried out for the 2010 NCT report "Left to your own devices: The postnatal care experiences of 1260 first-time mothers". The survey was conducted online, therefore it was not a local survey. However we cannot say it was a national survey either as the authors themselves recognise that the sample was not representative of the general population of first-time mothers in the UK. We therefore have not made the addition you request as we believe that either description (or 'online

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				survey') might mislead readers.
NHS England	General Background comment	General comment	The background could be improved by including some current evidence and references	Thank you for your comment. We appreciate your concern about providing detailed background information. The full guideline will contain the evidence and references, however the introduction is intended to provide only a brief description of the need for a full assessment of the evidence in the first instance.
NHS England	4	4-9	While we appreciate that the detail of what specialist care should constitute may need to be covered in separate guidance, we question the usefulness of providing guidance that covers only 'routine' care. We would question what 'routine care' constitutes in postnatal care, given the wide variety of women's individual needs, and where there is an increasing trend for babies to be observed closely after birth, due to various guidelines. This includes babies that are born to mothers who have had a raised	Thank you for your comment. This guideline aims to give recommendations for postnatal care of healthy mothers and babies (including postnatal

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			temperature in labour – even as a one off occurrence, babies who are born to mothers who might not have had 2 doses of antibiotics in labour for prolonged rupture of membranes etc. Guidelines will need to be explicit what is called as "normal" as the line between "routine" and "normal" observations of newborns in hospital can be thin. We think it would be helpful for any 'routine' pathway to consider key points of interface with these more specialist/additional services, including such things as: considering for every women what professional debrief or additional referral/follow up with service user may be required or desired at specific points, following complications in intrapartum care onwards.	complications), rather than addressing specialist postnatal care that may be required for example by women with pre-existing medical conditions. This is analogous to NICE guidance on intrapartum care of healthy women (CG190).This will normally map onto whether hospital readmission is required, but the committee will determine exactly where the distinction lies within the first few meetings. This will be made explicit through publication of protocols that will delineate the line adopted for the purpose of the guideline between 'routine' and 'non-routine'.

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NHS England	5	**Planning the content and delivery of care** Question What are the models for delivering the care?	Suggestion should new review question be "When should the first contact be made following **transfer** to **a community** setting?" – Women are not discharged from care until completion of postnatal event. [This is not consistent terminology as used in question 5 box 5 page 5	Thank you for your comment. We have made the change you suggested.
NHS England	5	**Question** What is the optimal number of postnatal contacts for the best outcomes?	Question – "What is the optimal number of postnatal contacts for the best outcomes? **Is this for mother and baby?**	Thank you for your comment. The question was originally intended to cover both mother and baby. As described in the table, however, there is good consensus that the optimal number of contacts varies with the specific needs and circumstances of the mother and baby and therefore there is no single 'optimum number', so the

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				question has been stood down.
NHS England	5	**Question** What information needs to be communicated between healthcare professionals at transfer of care?	Suggestion – reword What information needs to be communicated between healthcare Professionals **when a woman and her baby is transferred to community care**?	Thank you for your comment. We have changed the question to: What information needs to be communicated between healthcare professionals at transfer of care from place of birth to community care. This should be more responsive to the fact that not all women give birth in a hospital and then go straight home, as the original question implied.
NHS England	6	**Maternal health** What are the signs and symptoms of	Suggestion – reword – What fundamental core information and advice should be provided to ensure maternal and infant well-being	Thank you for your comment. This is an important area, and therefore we have included two questions. One is on self-care for the mother "What is the experience of

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		major physical morbidities (postpartum haemorrhage [PPH])?		mothers (from birth to 8 weeks, including transfer of care from place of birth to community care) as to when and how information is given to them regarding self-care?". The other is on information to ensure infant well-being "What information should be given to parents on routine care of babies?".
NHS England	6	What are the signs and symptoms of major physical morbidities (genital tract sepsis)?	New review question: How should early signs and symptoms of genital tract sepsis be detected? **Question should this also include what action should be taken?**	Thank you for your comment. The guideline will not cover the specialist care of women with genital tract sepsis, although will likely contain a recommendation on how signs and symptoms of genital tract sepsis can indicate an urgent and life-threatening condition, and therefore

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				immediate referral to a specialist is indicated.
NHS England	7	How should common health problems be identified and managed? (perineal pain)	How should common health problems be identified and managed? (perineal pain) **Question is this only pain and/or trauma and healing?**	Thank you for your comment. The new review question on perineal pain is based on the original question, but will no longer be looking at management. This is because there is no significant variation in practice about the management of routine perineal pain, and significant perineal complications including pain may need specialist management and so would be outside the scope of the guideline.
NHS England	General comment	General comment	There is a general absence of value of health promotion, whilst we appreciate this is covered in several of the cross referenced NICE guidance, it is a missed opportunity not to include this in the section regarding maternal health. This is a fundamental component of maternal	Thank you for your comment. While we cannot pre-empt recommendations made by the committee,

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			and child health during the postnatal period. One example is healthy eating and nutrition.	question 1.5 and 2.1 on the content of postnatal care contacts and information on self-care (respectively) may be an opportunity for the committee to consider the evidence on health promotion and make recommendations accordingly.
NHS England	General comment	General comment	Planning the content and delivery of postnatal care for women and babies will need to take into account recommendations and evidence from NICE guidance [NG4] Safe Midwifery Staffing – this should be cross referenced including any postnatal red flag events which may occur	Thank you for your comments, and thank you for highlighting this important piece of guidance to cross-refer to.
NHS England	10	New review question: When should a comprehensive, routine assessment of	Question – as there is no evidence for the maternal postnatal discharge examination could this even be 4 weeks?	Thank you for your comment. The intention of the question is to look for any evidence on the optimal timing of postnatal assessments, and therefore the committee could recommend 4 weeks if this

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		the woman at the end of the postnatal period occur (for example at 6 weeks, 8 weeks or not at all)?		is where the evidence points.
NHS England	!0	**Infant feeding** Do environmental factors (hospital practice; Baby Friendly Initiatives; roomin) facilitate effective breastfeeding?	Comment – should skin to skin be included here?	Thank you for your comment. The list of interventions to be included in the review will be defined by the committee in the first few meetings. While we cannot pre-empt guideline committee deliberation, skin to skin contact is expected to be considered a relevant intervention.
NHS England	12	**Infant feeding** What information offered to the woman and	Suggestion – reword What information should be offered to the woman and her partner to provide informed choice regarding formula feeding ?	Thank you for your comment. This question has been edited to: What information and support on formula feeding should be

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		her partner is more likely to enable women to formula feed?		provided to parents? After discussion, we decided not to make the second alteration you suggest as parents may need not only information to ensure informed choice regarding formula feeding, but also specific information on formula feeding (for example, temperature of feeds). Therefore the more general question allows the committee more scope to make helpful recommendations.
NHS England	12	**Maintaining infant health** Physical examination of the newborn	Comment – Should the question be "What is the optimal time to undertake a routine new-born screening assessment?"	Thank you for your comment. This guideline will not cover routine newborn screening assessment as there is already guidance in this area, for example the NHS newborn blood spot (NBS) screening

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				programme, and the NHS newborn and infant physical examination (NIPE) screening programme.
NHS England	General		No reference in the terminal list to Rhesus negative and administration of Anti D	Thank you for your comment. We checked the guideline you suggest including and note that the scope is only for antenatal Anti-D. Therefore we will not include it in the list of related guidance, as we would not want to give the impression NICE has guidance on postnatal Anti-D. Postnatal Anti-D is common practice (and covered by guidance elsewhere, such as the RCOG) so, after discussion, we have decided not to include it as a question.

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NHS England	General		Excellent this is a much needed guidance	Thank you for your kind comment.
Public Health England	General		Public Health England (PHE) and the Local Government Association have developed a Framework for supporting teenage mothers and young fathers – which includes actions for maternity services and we recommend that these actions are included in the scope of this consultation.	Thank you for your comment. The Framework is not the sort of evidence we would usually include in an evidence review since it is secondary analysis of the literature. However the committee are encouraged to use their background knowledge of the literature - including reports like the Framework cited in this comment - to inform their understanding of the evidence. Therefore your comment will be passed to the committee for their consideration.
Public Health England	General		The scope of the guideline only focuses in on young mothers under 18. We recommend widening the focus as most of the data relating to poorer outcomes for teenage parents and their children relates to under-20s.	Thank you for your comment. After discussion, we agreed that it was

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			There is also a very relevant report published last month by Action for Children which highlights the vulnerabilities of those who become parents between 20-24 – particularly around poor mental health. https://www.actionforchildren.org.uk/what-we-do/policy-and-research/good-mental-health-and-a-chance-to-thrive/the-next-chapter/	unhelpful to give a specific cutoff for the age at which a young woman stops being 'vulnerable'. We have therefore amended the equality considerations only to talk about 'young women', in the expectation that the committee will interpret this in accordance with your comment.
Public Health England	General		There is no mention of the role of fathers/partners in the post-partum period. PHE recommends including fathers/partners, particularly the mental health and wellbeing of fathers/partners and attachment/bonding.	Thank you for your comment. We have amended the outcomes to make it clear that those not relating to the physical trauma of birth are intended to refer to both the mother and the partner.
Public Health England	General		The majority of questions are acute/hospital focussed. It would be beneficial to expand to include more community matters as maternity systems are moving to promote a whole system, holistic approach to prevention to make it easier for women to receive the care and health	Thank you for your comment. We have changed the wording of the questions to reflect that

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			promotion advice they need and to be referred quickly to effective prevention services many of which are in the community.	there are a variety of settings not yet covered - most importantly changing all references to 'the home setting' to 'community care'.
Public Health England	General		The transition from Midwifery Care to Health Visiting is an important area of postnatal care and is not directly referred to. Health Visiting mandated contacts include antenatal, new birth visit, six to eight weeks so play a key role and contribution to the postnatal care period and these should be included in the scope of this document. Health Visiting High Impact Areas are as follows: • Transition to parenthood and the early weeks • Maternal mental health • Breastfeeding (initiation and duration) • Healthy weight, healthy nutrition (to include physical activity) • Managing minor illnesses and reducing hospital attendance/admissions Health, wellbeing and development of the child aged 2: Two year old review (integrated review) and support to be 'ready for school'	Thank you for your comment. We believe the areas you highlight as important are covered by our proposed review topics (with the exception of weight and nutrition advice, which is covered by other existing NICE guidance). Therefore if there is evidence on service delivery configurations for these topics the committee will be able to make recommendations on it.
Public Health England	5	**Planning the content and**	We agree that there is no general optimal number of postnatal care contacts, and that postnatal care should be decided based on each woman's circumstances.	Thank you for your comment. Although we cannot pre-empt

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		delivery of care What is the optimal number of postnatal contacts for the best outcomes?	However, PHE recommends posting a question relating to this point as follows: How can the provision of postnatal care contacts be tailored based on the health and social needs of mother and baby?	recommendations made by the committee, it is expected that they will use the opportunity afforded by question 1.3 to address the provision of postnatal care contacts based on the needs of the mother and baby.
Public Health England	5	**Planning the content and delivery of care** Review evidence: stand down original recommendations. New review question: What is the optimal	PHE agrees with this amendment	Thank you for your comment and support for this change.

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		content of the postnatal care contacts for women and babies?		
Public Health England	5	**Maternal health** What information needs to be communicated between healthcare professionals at transfer of care?	It is important to note the findings of Ofsted's Serious Case Reviews report (2011) looking at deaths of babies under the age of one year. The review highlighted the risks of vulnerable mothers falling through gaps during the transfer between maternity and health visiting and general practice. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526976/Ages_of_concern_learning_lessons_from_serious_case_reviews.pdf PHE also recommend that information about the mother's choice of postnatal contraception is shared between maternity and health visitors so follow up support can be provided.	Thank you for your comment. While we cannot pre-empt the findings of evidence reviews, it is likely that important and national databases such as the one you signpost to will be an important source of evidence for the committee in their deliberations.
Public Health England	6	**Maternal health**	There are no questions relating to maternal obesity, maternal mental health and domestic violence and the tools to identify and manage this effectively. Additional review questions should be added.	Thank you for your comment. Obesity is a medical complication which would make it outside the scope of the guideline. While we hope women with obesity

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				might be able to take advantage of some of the recommendations, those relating specifically to difficulties arising from obesity (for example, breastfeeding difficulties) cannot be covered. Maternal mental health is covered by NICE CG192 on antenatal and postnatal mental health. We will also include maternal mental health as an outcome to our evidence review searches, which the committee can choose to prioritise for questions where they believe it to be relevant. Domestic violence is covered by NICE PH50 on domestic violence and consequently out of scope

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				for this guideline (although it should be possible to signpost into the existing guidance at appropriate points).
Public Health England	9	**Maternal health** Postpartum contraception	There is a risk that the importance of postpartum contraception will be underplayed if only a link to the Faculty of Sexual and Reproductive Healthcare guidance is included rather than detailing it in the guidance. This may result in limited to no action being taken to improve staff awareness, training or women's choice. Therefore, the revised guideline should retain a recommendation about discussion and choice of contraception antenatally, with provision postnatally. PHE recommends considering the research of Sharon Cameron and Anna Glasier exploring women's views of Long-Acting Reversible Contraception provision immediately postnatally and the subsequent trial. http://srh.bmj.com/content/42/2/93. 'Contraceptive care or services' are excluded from the guideline but contraception discussion and linkage/referral should be included for the reasons listed above.	Thank you for your comment. It is the view of most stakeholders that effective contraceptive planning should begin before the postnatal period. Therefore effective discussion of contraception would be outside the scope of the guideline, and so to avoid misleading women and clinicians we believe a signpost to FSRH guidelines is the most appropriate way of addressing this issue.
Public Health England	9	**Maternal health**	The question should remain as it is important to protect future pregnancies from rubella. The word NHS England should be deleted and replaced with	Thank you for your comment. After discussion,

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		When is the optimal time to offer and administer maternal vaccination?"	Public Health England. In additional PHE recommends providing the link to the Rubella Chapter of the Green Book, rather than the document as a whole: https://www.gov.uk/government/publications/rubella-the-green-book-chapter-28	we felt that the guidance you link to is sufficiently comprehensive that it is not an effective use of resources to review the same evidence, and therefore will retain the exclusion of the question. Apologies also for the mis-attribution.
Public Health England	10	**Maternal health** The six to eight week maternal postnatal check	PHE recommends asking an additional question about how vulnerabilities are identified at all potential postnatal contacts including vulnerabilities such as adverse childhood experiences. It is important that the post-natal maternal review continues as this provides an opportunity for the healthcare professional to check the woman's Measles Mumps and Rubella immunisation status and offer any missing doses in order to protect future pregnancies against rubella.	Thank you for your comment on identifying vulnerabilities. We believe that the identification of vulnerabilities is covered in NICE CG 110 (pregnancy and complex social factors), and that the management of such factors will be well covered by making specific recommendations on these groups where the evidence supports it.

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				Thank you also for your comment on the post-natal maternal review, which we will pass on to the committee.
Public Health England	11	**Infant feeding** What should be done to prevent, identify and treat breastfeeding problem?	PHE agrees with the inclusion of the New review question: What are the facilitators and barriers for initiating and sustaining breastfeeding?	Thank you for your comment and support for this new review question.
Public Health England	12	**Infant feeding** What information offered to the woman and her partner is more likely to enable women to formula feed?	There are updated best practice guidelines for formula feeding/mixed feeding which should be included in the guideline. The recent Unicef responsive feeding and WHO guidelines for the amounts of feed for optimal nutrition and helping to prevent childhood obesity should be included.	Thank you for your comment. If these guidelines meet the inclusion criteria for the question then the committee will be able to consider them as sources of evidence.

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Public Health England	12	**Maintaining infant health** Physical examination of the newborn	This section should include specific reference to the inclusion of screening so would be useful to add a list of the newborn programmes and link to the national standards as these offer updated detail about specific requirements of the delivery of a safe and effective screening programme as below: *National NHS Screening programmes are :* • *Newborn and Infant Physical Examination Screening Programme* • *Newborn Blood Spot Screening Programme* • *Newborn Hearing Screening Programme* In this section there is no mention of vaccines given to babies because they are at increased risk of infection. For example neonatal Bacillus Calmette–Guérin (BCG) for those at higher risk of exposure to tuberculosis and neonatal hepatitis B vaccines for babies born to mothers who were found to be infected with hepatitis B during antenatal screening. Also reference to the complete physical examination of the baby which should take place within 72 hours of birth and again at six to eight weeks of age. Screening elements of the examination are: Eyes, heart, hips and testes (in boys). These examinations should be undertaken in line with the Newborn and Infant Physical Examination Screening Programme Guidance https://www.gov.uk/topic/population-screening-programmes/newborn-infant-physical-examination	Thank you for your comment. The guideline does not cover immunisation as this is covered by the Green Book. The guideline only covers the routine care required by women and babies, therefore it does not cover babies at increased risk of infection. Please note that BCG vaccination in neonates is covered by NICE guideline NG33 on tuberculosis. Please also note that hepatitis B immunisation in infants is covered by NICE clinical guideline "Hepatitis B (chronic): diagnosis and management" (CG165)

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Public Health England	13-14	Areas not covered by the guidelines	Areas not covered by the guidelines are logical but assessment of the mother/baby and review of these needs and referral/linkage are essential as part of the content for postnatal reviews.	Thank you for your comment. We are pleased you agree the areas for exclusion are logical. While we cannot pre-empt recommendations made by the committee, we would expect advice on when and how to refer to follow recommendations on what to look for.
Royal College of General Practitioners			The review questions, following a look at the evidence seem to be the pertinent questions in post-natal care – we are faced with women who may be depressed, in pain, lack sleep, perineal pain, genitourinary symptoms, breast feeding issues (need support from Health Visitors). There are also a cohort of women who are very happy and thriving – are there pre pregnancy and pregnancy factors that can predict for good quality of like post-delivery?	Thank you for your comment. While it would be extremely interesting to investigate the relationship between pre-pregnancy / pregnancy factors and good subsequent quality of life, such a question would be outside the scope of the guideline and therefore unfortunately cannot be considered by the committee.

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Royal College of Midwives	5	1. Planning the content and delivery of care New review question	Amend question to: 'When should the first contact be made following discharge from place of birth to community setting' Use 'place of birth' – rather than 'hospital' (see also comment 3 below) Use 'community' rather than 'home' setting (as in review question relating to item 5 in this section) Evidence about ' continuity of carer' should be included under planning content and delivery of care See for example: https://www.rcm.org.uk/sites/default/files/Continuity%20of%20Care%20A5%20Web.pdf http://www.gov.scot/Publications/2017/01/7728/8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4739100/	Thank you for your comment. In response to your comments we have changed 'home setting' to 'community care'. The question does not specify whether discharge is from the hospital or from a different place of birth, however we have amended similar questions to replace 'hospital' with 'place of birth'. Continuity of care may be prioritised by the committee as an outcome of interest in the planning of care, but we have elected not to ask a specific question on the topic as there is extensive guidance on this topic elsewhere.

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Royal College of Midwives	5	What is the optimal number of postnatal contacts for the best outcomes?	'optimal' number of contacts should be covered in relation to outcome of individual assessment An unforeseen impact of there being no statement about the 'optimal' number of postnatal visits in NICE PNC guidance has been that in the context of drive to ensure that women have 1:1 midwifery care throughout the whole of labour & birth, increasing financial constraints and midwifery staff shortage throughout the NHS, service managers have reduced 'routine' PNC to basic minimum across most of England. Indeed some trusts centralise delivery of 'required' aspects of routine care to hospital settings which means, for example, that women are expected to return to hospital clinic at 5 days after birth for neonatal screening blood test. In order to minimise further such unintended consequences for implementation of the new PNC guidance we suggest that under 'planning content and delivery of care' clear reference should be made to using individual risk assessment to plan and action care/interventions to achieve optimal outcomes (you have proposed questions on risk assessment in scope for maternal and infant health)	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, it is likely the committee will want to consider the issue of individual risk assessment.

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Royal College of Midwives	5	What information needs to be communicated between healthcare professionals at transfer of care?	Change new review questions as follows What information needs to be communicated between healthcare professionals at transfer of care from ~~hospital~~ place of birth to community setting? This covers obstetric and midwifery units: 'hospital' alone doesn't	Thank you for your comment. The question has been changed to: What information needs to be communicated between healthcare professionals at transfer of care from place of birth to community care?
Royal College of Midwives	6	Maternal health and wellbeing core information and advice	We suggest there should be a separate section about Infant health and wellbeing core information and advice rather than covering this under Maternal health In relation to the new review question ' What information should be given on routine care of babies ?'… …RCM welcomes the opportunity for consensus recommendations about infant skincare are updated by taking into account new evidence. – see forthcoming report of systematic review in Midwifery (January 2018)	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, it is not expected that information on the management of infant skincare will be included in the guideline (as we are aware of forthcoming Royal College of Midwives guidance on this topic), however identification of skin problems may be.

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			Cooke A et al. Skincare for health babies at term: a systematic review of the evidence. Midwifery 56 (2018) 29–43	
Royal College of Midwives	6	2.Maternal Health What are the signs and symptoms of major physical morbidities (postpartum haemorrhage PPH)	We do not agree that recommendations on PPH should be 'stood down'- this is the opportunity to review evidence on risk assessment and identifying when a woman is developing signs and symptoms to be able to prevent PPH The recently published National Maternal and Perinatal Audit report http://www.maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf demonstrates significant variation in rates of obstetric haemorrhage between units and regions in England. This suggests significant variation in practice eg in anticipation and ascertainment We suggest question should be 'How should early signs and symptoms of PPH be detected? '	Thank you for your comment. We have added a question on assessing early signs of postpartum haemorrhage.
Royal College of Midwives	12	4. Maintaining Infant Health	Change new review question as indicated 'What are the signs and symptoms ~~of~~ in babies that lead to hospital admission'	Thank you for your comment. We have re-written this question, and have included the change you indicate. The new

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				question reads "What signs and symptoms (alone or in combination) in babies are associated with serious illness or mortality?"
Royal College of Nursing	General	General	The Royal College of Nursing welcome proposals to update the Postnatal Care up to 8 weeks guidelines. The RCN invited members who care for women reviewed this document in its behalf. The comments below reflect the views of our reviewers.	Thank you for your support for updating the postnatal care guideline and for encouraging Royal College of Nursing members to review the draft scope.
Royal College of Nursing	4	6	There is no mention in the scope about multiple births and we hope they will be included and consideration given to the specific additional information and advice women and their partners will need about caring for two or more babies. Evidence shows that women with twins and triplets are less likely to breast feed for example. The incidence if depression is also higher". .	Thank you for your comment. Although the scope does not mention multiple births, multiple births are not excluded from the scope. This allows the committee to make recommendations on this topic if they uncover evidence on it.
Royal College of	General	General	Thank you for inviting the RCOG to comment on this comprehensive scope. There will be a number of significant changes to the content of the guideline	Thank you for your comment. We have re-

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Obstetricians and Gynaecologists			compared with the previous (2006) version with the removal of subjects covered by more recent and topic-specific guidelines. It would be helpful to see the final scope once the reasons for making the changes are removed.	written the table to make it clearer to follow the links between the original and proposed questions.
Royal College of Obstetricians and Gynaecologists	**6 of 20**		Is the section on the signs and symptoms of pre-eclampsia covered in the NICE Guideline Hypertension in Pregnancy (CG107)?	Thank you for your comment. The hypertension in pregnancy guideline (CG107) covers the first six weeks after delivery, whereas our scope covers the first eight. After discussion with clinical colleagues, we concluded there was no significant variation in management between week six and week eight, and consequently the signs and symptoms of pre-eclampsia were covered by existing NICE guidance. We have therefore decided to remove the question on assessing pre-eclampsia, as the patient population it

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				now covers is too small to uncover reliable evidence on.
Royal College of Obstetricians and Gynaecologists	**6 of 20**		Disagree with the statement that there is no significant variation in practice. The advice on how much bleeding to expect after having a baby, and the symptoms and signs to look out for are relevant information to be passed on to the woman.	Thank you for your comment. We have added a question on assessing early signs of postpartum haemorrhage.
Royal College of Obstetricians and Gynaecologists	**6 of 20**		The relevant question here is how women who have had pre-eclampsia or PIH should be managed after delivery.	Thank you for your comment. We believe the management during the first six weeks after delivery are covered by the scope of NICE guideline CG107 (hypertension in pregnancy). We have therefore decided to drop the question on assessing pre-eclampsia, as the patient population it now covers is too small to uncover reliable evidence on.

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Royal College of Obstetricians and Gynaecologists	**7, 8, 9 of 20**		Postnatal concerns about dyspareunia, constipation, haemorrhoid, faecal incontinence and urinary symptoms are common – whilst these are addressed in the current version of the guideline, I am not convinced that they will be captured in the proposed 'tools for clinical review', and certainly not by a MEOWS chart.	Thank you for your comment. We anticipate questions 2.2 and 1.5 being reviewed consecutively, so that if there are clinical tools which can address postnatal concerns about dyspareunia, constipation, haemorrhoid, faecal incontinence and urinary symptoms then these can be recommended as the optimal content of the postnatal care contact. If there are no such tools, or existing tools do not capture concerns adequately, the committee will be able to use consensus methods to address the topic in more detail in question 1.5. The MEOWS chart was only intended to be an

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				example of the sort of tool we proposed to assess, but we have removed the reference to prevent confusion.
Royal College of Obstetricians and Gynaecologists	**10 of 20**		Advice about what should be included in the postnatal check should be incorporated here.	Thank you for your comment. We intend to cover advice on what should be included in postnatal checks in 1.5 "What is the optimal content of the postnatal care contacts for women and babies?".
Royal College of Obstetricians and Gynaecologists	**10 of 20**		Advice about how to support women who are having problems breastfeeding and what services should be made available should be included in this section.	Thank you for your comment. The committee will look at interventions which can promote effective breastfeeding in question 4.5, and will therefore be able to make recommendations on supporting women who are

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				finding it difficult to breastfeed effectively if they uncover any evidence on this topic.
Royal College of Obstetricians and Gynaecologists	12 of 20		Grouping these questions into the two review questions will not provide advice for the management of these common conditions for GPs and health visitors/midwives. Using the criteria for hospital admission will fail to cover many of the problems listed which usually don't require hospital admission and are managed in the community setting.	Thank you for your comment. The management of maternal health conditions is outside the scope of the guideline, on the grounds that care for these conditions is either routine, with no variation in practice (in the case of minor presentations of these conditions) or suitable only for specialist management (in the case of severe presentations of these conditions). Question 1.5 and 2.1 are expected help clinicians understand if they should refer to hospital or manage in the community setting.

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Royal College of Obstetricians and Gynaecologists	**18 of 20**	13–15	First-time mothers ('new mothers') should receive different information from women who have already given birth.	Thank you for your comment. We see how this comment might be taken to be ambiguous and have reworded it to make it clear that we are talking about all mothers - regardless of parity - in the immediate postnatal period, with the intention of offering different information to different groups if this is appropriate and supported by evidence.
Royal College of Obstetricians and Gynaecologists	SIDS		Recommendations can and should be made in this area.	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"
Royal College of Obstetricians and Gynaecologists	SIDS		While there is clearly a lot of overlap between postpartum care and advice in other NICE guidelines it is often helpful for this advice to be reiterated in the one document for the healthcare professional to easily access rather than cross referencing with multiple other documents. NICE may wish to consider this form a user friendly point of view when completing this document.	Thank you for your comment. NICE process is only to cross-refer where other guidelines contain relevant recommendations, not duplicate those recommendations. This is because it allows these guidelines to be updated independently of each other, so that NICE can respond rapidly to new developments in the field.

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Royal College of Paediatrics and Child Health			In addition to all of the points covered in the draft scope, we strongly encourage assessment/consideration of alternative arrangements for immediate postnatal care in health care facilities, specifically provision of Neonatal Transitional care. We also recommend that features of the ATAIN programme are considered, as the aim should be to reduce maternal/infant separation whenever possible,	Thank you for your comment. Unfortunately we are not able to consider Neonatal Transitional care as this would potentially conflict with other NICE guidelines. However we have amended all references to 'the home setting' to read 'community care' in order to take into account alternative community arrangements for postnatal care.
Royal College of Paediatrics and Child Health	11	Tongue tie	The NICE guidance on ankyloglossia is old (IPG 149, 2005), so it is unfortunate that the proposed postnatal guidance does not propose to update it as there have been several trials reported since 2005.	Thank you for your comment. We appreciate your concern about the need to update the existing IPG on ankyglossia; however, the it would not be appropriate to review topics upon which there is already existing NICE guidance. We

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				will notify the updates team of the existence of new trials since 2005, which may alter their subsequent decisions to update the guideline or not.
Royal College of Paediatrics and Child Health	12	**Interventions that promote attachment**	The scope document suggests that this issue is covered in CG192. It is not. CG192 deals with mothers with pre-existing or newly arising psychiatric issues, and has nothing to say on promoting and maintaining optimal mother-infant interactions for mother who are not psychiatrically ill. There is a substantial literature on this topic, and it is very important to promote attachment security for the sake of preventing mental disorders and promoting resilience in later childhood and adulthood, so it should be reviewed in this update.	Thank you for your comment. After discussion, we have concluded that attachment is sufficiently important that it should be regarded as an outcome of all mother / baby interaction, and not as a review question in itself. Therefore it will be included in the guideline as an outcome, and the committee will be able to make recommendations on it in that context, if they choose.

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Royal College of Paediatrics and Child Health	12	Physical examination of the newborn	It appears that the review will not address the physical examination of the newborn. This is fine as it is now part of the NSC NIPE programme. It will instead address two separate issues: the assessment of illness in infants of 8 weeks or less, and the management of common minor problems (which are specified). In relation to the assessment of illness, it will be important for NICE to review the publications on Baby Check, which though a bit old, have not been superseded.	Thank you for your comment. While the guideline will address the physical examination of the newborn in existing question 1.5 ("What is the optimal content of the postnatal care contacts for women and babies?") and a redrafting of 3.1 ("What signs and symptoms (alone or in combination) in babies are associated with serious illness or mortality?"), the focus of the review will be different to the NSC NIPE programme, so we are pleased that this decision is suitable to you. We will review the additional publications you cite when drafting the review protocols in the first few meetings.

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Royal College of Paediatrics and Child Health	18	Lines 5-6	This should specify routine contact: '1.3 When should the first routine contact be made following discharge to the home setting?	Thank you for your comment. We have made the change you suggested.
Royal College of Paediatrics and Child Health			BAPM strongly supports development of this updated guidance	Thank you for your comment and support for this guideline update.
Royal College of Psychiatrists	3	16	Equality considerations: Women with mental health problems have difficulty with equality of access, and simply including them among "vulnerable women" is insufficient. Additionally, the siblings of the new babies born into the family of women with MH problems may be at increased risk, so should be included in the scope of the guidance	Thank you for your comment. The equalities section has been amended in line with this comment.
Royal College of Psychiatrists	5	Part in table that says – 'No evidence review: stand down original recommendations. Professional competencies are now outside the	While this is true, it is essential that interventions and assessments be described in sufficient detail to ensure that competencies can be derived. Otherwise the recommendations simply become empty "forms of words"	Thank you for your comment. Unfortunately NICE guidelines are not allowed to consider level of qualification, as this is the remit of professional bodies. Consequently when writing recommendations we will – where possible - use forms of words commensurate with the competency frameworks of the relevant

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		scope of NICE guidelines.'		professional organisations in order that it is clear how to derive competencies from these.
Royal College of Psychiatrists	6	Part of the table that says - 'New review question: What is the experience of new mothers (from birth to 8 weeks, including discharge) as to when and how information is given to them regarding self-care?'	Should the review also cover what the best experience should be? as well as what is?	Thank you for your comment. We have left "what is the experience" without adding "what should be the best experience", because different women may have different views of what is a "best experience". However, the review will not only look at women's past experiences but also at their views and opinions on what needs to be improved and what is important to guarantee a good experience. We believe this is implicit as the ultimate aim of the review is to inform recommendations, and therefore the committee

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				will be able to make recommendations on improving experience even in the absence of the change you suggest.
Royal College of Psychiatrists	7	Part of the table that says – 'How should common health problems be identified and managed? (perineal pain)'	There should also be a cross-reference to antenatal and postnatal mental health, as pain may be a symptom of psychological ill-health also. This note also applies to dyspareunia, headache, fatigue and constipation.	Thank you for your comment. As we are not standing down this question we think it would be more appropriate to make the cross-reference directly in the recommendations rather than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee.
Royal College of Psychiatrists	10	Part of the table that says - 'The six to eight week maternal	Again, will need a cross-reference to antenatal and postnatal mental health	Thank you for your comment. As we are not standing down this question we think it would be more appropriate to make the cross-reference directly in

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		postnatal check'		the recommendations rather than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee.
Royal College of Psychiatrists	10	Part of the table that says 'Do environmental factors (hospital practice; Baby Friendly Initiatives; room-in) facilitate effective breastfeeding? '	We are not sure that the collapse into the proposed two categories is sufficiently clear, as "enabling" and "ensuring" are so close. Could we suggest "initiating" and "maintaining" instead?	Thank you for your comment. We have made the change you suggested.
Royal College of Psychiatrists	12	Physical Examination in the newborn	I'd like to see explicit cross-references to both antenatal and postnatal mental health, and child maltreatment recommendations here	Thank you for your comment. As we are not standing down this question we think it would be more

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				appropriate to make the cross-reference directly in the recommendations rather than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee.
Royal College of Psychiatrists	18	10-11	This should reference both the antenatal/postnatal mental health and child maltreatment recommendations	Thank you for your comment. We will ensure the table references both the antenatal / postnatal mental health (CG192) and child maltreatment (CG89) guidelines.
Royal College of Psychiatrists	18	22-23	Recommendation to cross-link to antenatal/postnatal mental health here	Thank you for your comment. As we cannot pre-empt committee deliberations, we think it would be more appropriate to make the cross-reference directly in the recommendations rather

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				than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee.
Royal College of Psychiatrists	18	25-26	As commented above, this should be references to both antenatal/postnatal mental health & child maltreatment. Recommended tools should include those for early social-emotional as well as physical development.	Thank you for your comment. As we cannot pre-empt committee deliberations, we think it would be more appropriate to make the cross-reference directly in the recommendations rather than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee. Your second comment is about what the recommended tools should include. The exact review protocols will be finalised by

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				the committee in the first few meetings, but it is likely the committee will want to consider social-emotional development as well as physical development, since this is one of their key outcomes.
Royal College of Psychiatrists	18	29-30	This should be cross-referenced to the child maltreatment guidance	Thank you for your comment. The guideline is cross-referenced to the child maltreatment guideline (p17 l27) and we would expect to cross-refer within the recommendations themselves where appropriate.
Royal College of Psychiatrists	General	General	Need to make sure there's sufficient cross-referencing to the antenatal/postnatal mental health and child maltreatment guidance.	Thank you for your comment. As we cannot pre-empt committee deliberations, we think it would be more appropriate to make the cross-reference

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				directly in the recommendations rather than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee.
Royal College of Psychiatrists	General	General	Maternal pain and discomfort can be symptomatic of mental as well as physical ill-health, so these sections need cross-referencing too.	Thank you for your comment. As we cannot pre-empt committee deliberations, we think it would be more appropriate to make the cross-reference directly in the recommendations rather than on the scope. Consequently we have taken no action now, and will pass on your comment to the committee.
Royal College of Psychiatrists	General	General	Need to stress the psychosocial early development of infants, as a possible marker of a need for safeguarding, as well as potential early psychosocial issues	Thank you for your comment. While we cannot pre-empt recommendations

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				made by the committee, psychosocial early development of infants is an outcome which can be considered and therefore the committee could make recommendations on it in the context of safeguarding, or cross reference into existing NICE guidance on safeguarding.
Royal College of Psychiatrists	General	General	Need to identify the siblings of mothers with known mental health problems as being a group who might require especial support after the birth of a new baby, under the "equality" considerations. (I also flagged this group of mums as needing special consideration, given their greater difficulty in accessing services)	Thank you for your comment. The equalities section has been amended in line with this comment.
Swansea University	4	23	• Depends on parity, type of delivery and any health or medical conditions Recommendations day 1 for primips or high risk women or a phone call for low risk women to arrange visit. • Promote early discharge from all birth settings • Increase antenatal health promotion to include indepth postnatal care	Thank you for your comment. While we cannot pre-empt recommendation made by the guideline committee, it is likely that they will want to make different recommendations for women with different

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			• Woman's history and appropriate care plan • Make more use of the NNEB's, MSW's student midwives, G.P.'s and Breastfeeding support groups. • The investment in Health promotion antenatal to include postnatal care and common postnatal illnesses i.e. UTI, mastitis and more serious conditions i.e. sepsis will ultimately lead to a reduction in financial burden. • Make use of other health care professionals i.e. OT's, physiotherapists, local sexual health clinics and G.P's. referral to local lactation consultants and peer support groups Infants to be fully stripped at each visit	parity, delivery type or other factors if the evidence is robust enough to support such a distinction.
The Lullaby Trust	13	n/a (table)	***What is the risk of co-sleeping in relation to sudden infant death syndrome (SIDS)?*** ***No evidence review: stand down original recommendations. There is no significant variation in practice, so recommendations from NICE are not needed in this area.*** We strongly disagree that there *is 'no significant variation in practice, so recommendations from NICE are not needed in this area.'* It is not clear in the draft scope whether this refers to the practice of healthcare professionals or of new parents/carers, whom the guidance also covers. However, taken in either context, we know that significant variation in practice does exist, and therefore it is crucial for the recommendations to remain in the guidance to ensure families are receiving the best possible	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant

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			care during the postnatal period. We would be very interested to know how variation has been measured during this consultation and what the evidence is for this. Taken to mean the practice of the healthcare professionals who discuss co-sleeping with parents, our Regional Development Officers (RDOs) interact with hundreds of professionals via safer sleep training sessions every year and are certain that the current recommendations are not being followed in a uniform way. This may be due to a variety of factors including time constraints, confusion regarding the wording of the guidance, or personal views on bed-sharing, which often become apparent during training sessions. One professional told us that the introduction of the 2014 guidelines *"caused a lot of controversy and have only recently begun to be fully understood* [by professionals] *to be confident enough to have the necessary conversation with parents"*. Although some professionals do appear to be giving co-sleeping advice as currently recommended, others have been unaware of even the association between co-sleeping and sudden infant death syndrome (SIDS). When asked what they would change in their practice **as a result of the training**, one health visitor said that they would *"give choice if a parent wants to co-sleep"*, and another said they would *"discuss risk factors with clients".* RDOs cover the entirety of England (as well as Wales and Northern Ireland) and have found significant regional variation: some services and trusts have good safer sleep guidelines and pathways for giving the advice postnatally,	sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			whilst others do not. At least one area of England has recommended a blanket ban on co-sleeping following deaths in which co-sleeping was involved, which does not follow current guidance. In other areas, it has been observed that bed-sharing is encouraged in order to promote breastfeeding. Parents, including those bereaved by SIDS, have also told our RDOs that much inconsistency in advice exists between different healthcare professions, e.g. doctors/midwives/health visitors, and between settings, i.e. the hospital vs community environment. One mother who was on a postnatal ward for six days told us that she received no advice regarding co-sleeping, despite falling asleep with her baby on her chest several times in hospital. A group of six young mothers reported that they received either a blanket ban on co-sleeping from health visitors, or no advice at all. One relied on the advice of her family nurse to give a more detailed explanation of the risks associated with co-sleeping.	
The Lullaby Trust			Research shows that there is much variation in professional opinion in safer sleep advice. A recent meta-analysis[1] looking at healthcare professionals' practice regarding sleeping position and SIDS risk found that only 80% recommended the supine position exclusively, despite supine sleep being one of the clearest and best-supported SIDS risk-reduction messages. If such variation exists related to the relatively unambiguous 'back to sleep'	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to

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			recommendation, it is highly unlikely that the more nuanced co-sleeping recommendations would be given in a more uniform way. Another study, [2] published this year, found that professionals were influenced by whether women already had children, as *'it was taken for granted that they would have heard the advice before.'* (p3). That study also provides evidence for the significant variation in parental practice when it comes to co-sleeping. There are many influences on decision-making for an infant's sleep environment, including using maternal instinct, previous experience, prioritising longer infant sleep, and favouring the recommendations that made the most sense or enabled mothers to feel they were enacting a safer sleep environment, despite not following the recommended advice.[2] With such a diverse range of influences and factors, holding nuanced conversations about where and how a baby should sleep, supported by clear guidance, is key to enabling parents to make safer decisions and reduce the risk of sudden infant death. Co-sleeping is too important an issue not to be recognised in NICE guidance. Autopsy findings have confirmed the link between co-sleeping and sudden infant death,[3] and hazardous co-sleeping, often involving a drugs or alcohol or sofa-sharing, is common feature in sudden infant deaths discussed at Child Death Overview Panels (CDOPs) across the country. The proposed development of a national CDOP database will make the significance of hazardous co-sleeping more apparent, but at present our RDOs and the professionals we work with are aware of many investigations	stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			in which the high-risk co-sleeping environment has been a key contributory factor to the death, and might have been avoided. For example, there were 23 sudden unexpected infant deaths in the London borough of Brent between 2008 and 2017, of which 13 involved co-sleeping.[4] A recent review of police investigations into sudden infant death[5] found 40% occurred in a co-sleeping scenario, in which many cases parents sofa-shared, smoked or consumed alcohol or drugs. Removing co-sleeping recommendations would disproportionately affect young women and vulnerable women; groups whom the draft scope identifies as in need of special consideration in terms of equality. Younger maternal age and higher levels of socioeconomic deprivation have long been recognised as important risk factors for sudden infant death, and deprivation has been observed to be associated with hazardous co-sleeping (i.e. involving smoking, alcohol, drugs or sofa-sharing).[5] Such families have lower awareness of risk factors for SIDS in general, including practices like sofa-sharing.[6] Stripping co-sleeping recommendations from the guidance would not only be in contradiction of the aims to the guidance for patient-centred care, in *which 'patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals'* but would disadvantage the families in most need of support.	

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The Lullaby Trust			Co-sleeping was deemed to be an important enough issue to form an addendum to the guidance less than three years ago. In the time since there has been no evidence to show that co-sleeping is any less of a risk or any better understood by professionals or parents, and the burden of sudden infant deaths that take place in high-risk co-sleeping situations has not changed. Even if there is no significant variation in practice as stated, removing this guidance may simply lead to a relapse to whatever the unsatisfactory practice was before the co-sleeping recommendations were added. As one health visitor told us, *"Co-sleeping needs to remain in the guidance. There is a danger that if it is not written within guidelines the issue of co-sleeping will be passed over - not thought to be important or relevant."* Co-sleeping remains an important issue in infant care, and healthcare professionals are a key source of safer sleep information for parents.[1] They must have as much resource as possible in the form of recognised guidance to support families to reduce their risk of sudden infant death. 1. de Luca F, Hinde A. Effectiveness of the 'Back-to-Sleep' campaigns among healthcare professionals in the past 20 years: a systematic review. *BMJ Open.* 2016;6:e011435. doi:10.1136/bmjopen-2016-011435 2. 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. 3. Weber MA, Risdon RA, Ashworth MT, Malone M, Sebire NJ. Autopsy findings of co-sleeping-associated sudden unexpected deaths in infancy: relationship between pathological features and asphyxial mode of death. *J Paediatr Child Health*. 2012 Apr;48(4):335-41. doi: 10.1111/j.1440-1754.2011.02228.x. Epub 2011 Oct 21.	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			4. Brent Local Safeguarding Children Board. *Child death overview panel annual report: 1st April 2016–31st March 2017.* Available at: http://democracy.brent.gov.uk/documents/s59016/Appendix%201%20%20Full%20Brent%20Child%20Death%20Overview%20Panel%20Annual%20Report.pdf [Accessed 14/11/2017] 5. Bamber AR, Kiho L, Upton S, Orchard M, Sebire NJ. Social and behavioural factors in Nonsuspicious unexpected death in infancy; experience from metropolitan police project indigo investigation. *BMC Pediatrics* 2016.16:6. DOI 10.1186/s12887-016-0541-x 6. Pease AS, Blair PS, Ingram J, Fleming PJ. Mothers' knowledge and attitudes to sudden infant death syndrome risk reduction messages: results from a UK survey. *Arch Dis Child.* 2017. Aug 16. pii: archdischild-2017-312927. doi: 10.1136/archdischild-2017-312927.	
The Lullaby Trust	18	10	**1.5 What is the optimal content of the postnatal care contacts for women and babies?** 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 a leading cause of postneonatal mortality[1] which can and should be addressed in the postnatal period, when infant care routines are becoming established. We have commented separately on the need to retain co-sleeping recommendations within the guidance, which is 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	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant

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			sleep practices have become standard. The Office of National Statistics mentioned safer sleep campaigns as a possible reason for the recent record low in 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 cases[7] and research has also highlighted smoking in the postnatal period as a significant risk factor.[8] We are aware 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. 1. Office for National Statistics. *Childhood mortality in England and Wales: 2015*. Available from:	sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2015 [Accessed 14/11/2017]. 2. 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]. 3. Moon R, Hauck F, Colson E. Safe infant sleep interventions: what is the evidence for successful behavior change? *Curr Pediatr Rev.* 2016;12:67-75. 4. 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. 5. The Lullaby Trust. *Evidence Base*. Available from https://www.lullabytrust.org.uk/wp-content/uploads/Evidence-Base-2016.pdf [Accessed 14/11/2017]. 6. NHS Choices. *Reduce the risk of sudden infant death syndrome (SIDS).* Available from: https://www.nhs.uk/conditions/pregnancy-and-baby/pages/reducing-risk-cot-death.aspx [Accessed 14/11/2017] 7. Wisborg K, Kesmodel U, Henriksen TB, Olsen SF, Secher NJ. A prospective study of smoking during pregnancy and SIDS. *Arch Dis Child.* 2000;83(3):203-6. 8. Liebrechts-Akkerman G, Lao O, Liu F, van Sleuwen BE, Engelberts AC, L'Hoir M P, et al. Postnatal parental smoking: an important risk factor for SIDS. *Eur J Pediatrics.* 2011;170(10):1281-91.	
The Lullaby Trust	18	27	**3.2 What information should be given to parents on routine care of babies?** Infant sleep is an important component of healthy development and safety, as well as parental wellbeing, and would be helpful for parents to be included about information about routine care. This information could	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to

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			encompass how to sleep babies to reduce the risk of sudden infant death, for example avoiding prone and side positioning. Sleeping babies in the supine position has saved countless babies' lives worldwide since the 'Back to Sleep' campaigns of the early 1990s, yet it is still far from 'routine' care: a recent study[1] found less than half of parents slept their baby in the supine position, while another demonstrated that a similar proportion of mothers at higher risk of SIDS knew supine positioning reduced the risk.[2] As infants spend so much of their early lives asleep (or being settled by their parents in the hope of sleep), consideration of sleep and how it changes as part of normal infant development would help to ensure babies are slept more safely, and support parents. Many parents are unprepared for the level of sleep disturbance a new baby brings, and have unrealistic expectations about how their baby should sleep.[3] This can not only have a negative impact on parents' emotional state, but also lead them to make decisions that may compromise their babies' safety, such as use of sleep positioners, which have been the subject of health warnings from governments of the US[4] and Canada[5] in recent months. Although 'normal' infant sleep patterns can vary quite widely, [3] educating parents about what they might expect could empower them to provide optimal care during periods of sleep deprivation.	stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			1. Colson ER, Geller NL, Heeren T, Corwin MJ. Factors associated with choice of infant sleep position. *Pediatrics.* 2017 Sep;140(3). pii: e20170596. doi: 10.1542/peds.2017-0596. 2. Pease AS, Blair PS, Ingram J, Fleming PJ. Mothers' knowledge and attitudes to sudden infant death syndrome risk reduction messages: results from a UK survey. *Arch Dis Child.* 2017. Aug 16. pii: archdischild-2017-312927. doi: 10.1136/archdischild-2017-312927. 3. Russell CK, Robinson L, Ball HL. Infant sleep development: location, feeding and expectations in the postnatal period. *Open Sleep Journal* 2013. 6;(Suppl 1:M9) 68-76. 4. US Food and Drug Administration. *Do not use infant sleep positioners due to the risk of suffocation.* Available from: https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm227575.htm [Accessed 14/11/2017]. 5. Health Canada. Consumer Product Update: Health Canada warns Canadians of health and safety risks of baby nests. Available from: http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/64318a-eng.php [Accessed 14/11/2017]	
The Lullaby Trust	18 19 19	32 1 5	**4.1 What information and support on breastfeeding should be provided to parents?** **4.4 What are the facilitators and barriers for initiating and sustaining breastfeeding?** **4.5 What interventions in the 8-week postnatal period are effective in enabling successful breastfeeding?** Parents should be informed that breastfeeding has a protective effective on SIDS. The most recent study, a large meta-analysis of eight international case-control studies,[1] found that breastfeeding for only two months was	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will

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			effective to significantly reduce the risk, although longer durations were more protective. After two months' duration there was no significant difference between exclusive breastfeeding and mixed feeding, although earlier studies have suggested exclusive feeding confers the greatest protection.[2] Dummy use and breastfeeding have shared a contentious relationship as dummies are similarly protective against SIDS, but have been perceived to inhibit breastfeeding. However, the most recent research suggest this may not be the case: a 2016 Cochrane review[3] did not find any evidence that dummies disrupted breastfeeding; the same findings as a 2015 meta-analysis that concluded dummies are likely to be offered as a consequence of breastfeeding difficulties rather than being a cause of them. [4] If parents would like to use a dummy they should be informed of its protective effective on SIDS, and to follow current Lullaby Trust advice to offer it after breastfeeding is well-established and to withdraw between six and 12 months. Parents should continue to be advised that dummies should be used consistently for every sleep and not suddenly withdrawn, as currently recommended in the guidance (recommendation 1.4.50). For some social and cultural groups, breastfeeding and bed-sharing appear to be closely related.[5] In discussions of effective interventions or facilitators for breastfeeding, in which bed-sharing is likely to come up, it is paramount that its association to SIDS is not ignored. As currently recommended in the guidance, should parents intentionally choose to bed-share to facilitate	therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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			breastfeeding, they must receive information about the circumstances that make it more risky, such as if they smoke or have drunk alcohol. The Unicef leaflet endorsed by the Lullaby Trust and the Infant Parent Sleep Source at Durham University, '*Caring for your baby at night*'[6], with versions for parents and professionals, contains information on how to bed-share more safely and would be a useful tool for conversations about bed-sharing and breastfeeding. 1. Thompson J, Tanabe K, Moon RY, Mitchell EA, McGarvey C, Tappin, D et al. Duration of breastfeeding and risk of SIDS: an individual participant data meta-analysis. *Pediatrics.* 2017;140(5):e20171324. 2. Hauck FR, Thompson JM, Tanabe KO, Moon RY, Vennemann MM. Breastfeeding and reduced risk of sudden infant death syndrome: a meta-analysis. *Pediatrics.* 2011;128(1):103-10. 3. Jaafar SH, Jahanfar S, Angolkar M, Ho JJ. Pacifier use versus no pacifier use in breastfeeding term infants for increasing duration of breastfeeding. *Cochrane Database of Systematic Reviews* 2011, Issue 3. Art. No.: CD007202. DOI: 10.1002/14651858.CD007202.pub2. 4. Alm B, Wennergren G, Möllborg P, Lagercrantz H. Breastfeeding and dummy use have a protective effect on sudden infant death syndrome. *Acta Paediatr.* 2015.Jul14. doi: 10.1111/apa.13124.	
The Lullaby Trust	19	1	5. Ball HL, Howel D, Bryant A, Best E, Russell C, Ward-Platt M. Bed-sharing by breastfeeding mothers: who bed-shares and what is the relationship with breastfeeding duration? Acta Paediatr 2016. Feb 5. doi: 10.1111/apa.13354. [Epub ahead of print]. 6. Unicef UK. *Caring for your baby at night*. Available at: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/leaflets-and-posters/caring-for-your-baby-at-night/ [Accessed 14/11/2017]	Thank you for your comment. We will review these publications when drafting the review protocols. If deemed relevant by the committee,

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				we will forward this reference to our information specialist to inform the search strategy. This is to ensure that this and similar publications are identified when reviewing the evidence.
The Twins and Multiple Birth Association	10	Section 3 infant feeding	Review Question: What interventions in 8 week postnatal period are effective in enabling breastfeeding/sustaining breastfeeding and supporting bottle feeding choices? **Please consider mentioning specific need for additional support for multiples mothers' breastfeeding.** Tamba report Tamba and NCT Maternity Services Report: Multiple births - produced by Tamba in 2015 found *Feeding multiples provides additional challenges and mothers may find that they are unable to feed their babies in the way that they intended. 29.6% of parents said they had not been able to feed their babies as planned, often due to lack of breastfeeding support, pressure to supplement with formula, difficulties with feeding premature babies, separation from one/more babies, or the sheer demand of breastfeeding multiples. 33.2% were able to breastfeed, whilst 27.3% were able to express feed. 21.5% decided to mix feed, 20.3% to use formula milk and 2.8% to use donor milk.*	Thank you for your comment. We cannot pre-empt recommendations made by the committee, but it is likely they will want to consider multiple births as a subgroup. This would mean that specific recommendations could be made on supporting mothers of multiple infants if evidence was uncovered on the topic.

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			Parents may also be more likely to experience problems with feeding their babies due to difficulties of prematurity, illness, separation, lack of feeding support, or the sheer demands of feeding multiples, with 29.6% of parents saying they were unable to feed their babies as planned.	
Twins and Multiple Birth Association	5	Section 1 planning the content & delivery of care	Review Question: How does length of postpartum stay impact on women & babies? **Please consider mentioning specific need for additional support for multiples mothers' on the postnatal ward when 1 or more multiple birth babies are in neonatal care** Tamba report Tamba and NCT Maternity Services Report: Multiple births - produced by Tamba in 2015 *This is reflected in the survey findings with over half (51.5%) of respondents stating that one or more of their babies required some kind of additional care in a neonatal unit after birth. Of these 42.2% were in a Level I Special Care Baby Unit (SBCU), 25% were in Level II High Dependency Unit and 28.4% were in Level III Neonatal Intensive Care Unit (NICU). In most cases (82.5%) parents reported that the hospital automatically offered to keep all their babies together, although 3.2% had to argue for places for all of their babies.*	Thank you for your comment. We cannot pre-empt recommendations made by the committee, but it is likely they will want to consider multiple births as a subgroup. This would mean that specific recommendations could be made on supporting mothers of multiple infants if evidence was uncovered on the topic.
Twins and Multiple Birth Association	6	Section 1	Review Question: What information should be given to parents on routine care of babies? **Please consider mentioning specific need for additional support for multiples mothers' on routine care of multiples babies** Tamba report Tamba and NCT Maternity Services Report: Multiple births Only 42.1% of parents completing the survey had been given advice on safe sleeping for multiples, showing room for improvement in this area.	Thank you for your comment. We cannot pre-empt recommendations made by the committee, but it is likely they will want to consider multiple births as a subgroup. This would mean

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			Tamba have lots of best practice resources to support parents and health professionals in this area	that specific recommendations could be made on supporting mothers of multiple infants if evidence was uncovered on the topic.
UK Clinical Pharmacy Association (UKCPA): Women's Health Group	Section 2 p9	Postpartum contraception	No evidence review: stand down original recommendations. This is covered by the Faculty of Sexual and Reproductive Health guideline on contraception after pregnancy. Can you clarify if this would be totally removed? Would you consider including a link to this contraception after pregnancy guidelines as this is not a NICE related guidance.	Thank you for your comment. While we cannot pre-empt recommendations made the committee, it is likely that they will want to include some link to the FSRH guidance.
UK Clinical Pharmacy Association (UKCPA): Women's Health Group	Section 3 p10	Under Infant Feeding	*Consider to add a new topic to include, preferably under 'infant feeding' which is not currently in the 2006 guidance, "What advice should be given to mothers around taking medicines whilst breastfeeding". The new information would provide some reassurance to mothers who have concerns about drugs crossing over into the baby, which in turns create barriers to breastfeeding for some mothers. Signposting to local hospital medicines information or NHS Choices for further information.*	Thank you for your comment. While we cannot pre-empt recommendations made by the committee, the intention of question 4.4 on the facilitators and barriers to breastfeeding was to address concerns mothers may have on medicines given while breastfeeding.

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				Depending on the evidence they uncover, the committee may wish to make associated recommendations.
UK Clinical Pharmacy Association (UKCPA): Women's Health Group	Section 4 p12	Under Maintaining infant health	*Consider including "What medicinal or non-medicinal treatments may be safely offered for the management of common conditions seen in the newborn?"*	Thank you for your comment. We have taken the decision to exclude the management of these common conditions because stakeholder feedback is that the management of these conditions is not notably variable until the condition because serious enough to require hospitalisation. We have therefore added a question on situations when this might be the case; "What signs and symptoms (alone or in combination) in babies are associated with

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				serious illness or mortality?".
UNICEF UK & National Infant Feeding Network	1	26	Evidence shows that the mother-infant relationship has a profound impact on the short and long term health and wellbeing outcomes of the child. As such we recommend that line 26 read "…health, infant feeding and relationship building." (Unicef, 2017, Early moments matters: for every child)	Thank you for your comment. We have made the change you suggested.
UNICEF UK & National Infant Feeding Network	3	4	The draft scope currently excludes people who provide voluntary/peer support. We feel this group should be included because a significant amount of infant feeding support is provided by mother to mother support in women's own locality e.g. Breastfeeding Network, NCT, Association of Breastfeeding Mothers, La Leche League etc. We suggest that a bullet point is added after line 4 reading: "Voluntary/peer infant feeding supporters."	Thank you for your comment. We have updated the guideline population section (Who the guideline is for) to include a reference to this group.
UNICEF UK & National Infant Feeding Network	4	11	The introduction highlights that the emotional needs of mothers are not currently being met (page 2 line 12). As such, we recommend that the key area is amended to include this: 2. Identifying and assessing health and wellbeing needs in women	Thank you for your comment. After discussion we have not made the change you suggested. Although we agree the guideline should consider health and wellbeing, the implication of separating them is that 'health' is somehow distinct from

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				'wellbeing' (for example that they are two separate processes). Since this is not the impression we want to give, we will use the word 'health' throughout to mean 'health and wellbeing'.
UNICEF UK & National Infant Feeding Network	4	12	Taking into account the impact of early relationships on the newborn infant we recommend that .the key area is amended to include this: 3. Identifying and assessing health and wellbeing needs in babies	Thank you for your comment. After discussion we have not made the change you suggested. Although we agree the guideline should consider health and wellbeing, the implication of separating them is that 'health' is somehow distinct from 'wellbeing' (for example that they are two separate processes). Since this is not the impression we want to give, we will use the word 'health' throughout to mean 'health and wellbeing'.

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UNICEF UK & National Infant Feeding Network	11	First point in the table page 11– How should breastfeeding be assessed	Evidence shows that clinicians and mothers don't always know what effective feeding looks like and how to assess this – often leading to cessation of breastfeeding and introduction of formula milk. We know that ineffective assessment of milk transfer and effective breastfeeding can lead to re-admission to hospital for jaundice, weight loss etc. See Unicef Baby Friendly Breastfeeding Assessment form also included in the National Maternity Notes In light of this, we would suggest a new review question: How should breastfeeding be assessed or What tools for clinical review of breastfeeding are effective during the first 8 weeks after birth (for example: Breastfeeding assessment form)?	Thank you for your comment. A separate question on the assessment of successful breast feeding was not prioritised as we expect these indicators to arise from question 4.5 on interventions which promote successful breastfeeding. The outcomes for this question will be chosen by the multidisciplinary committee as to represent 'successful' breastfeeding, based on their professional experience and knowledge of the topic. We will follow the GRADE methodology (which requires identifying critical and important outcomes). This should allow the committee to make more nuanced recommendations on this

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				very important topic, because it will mean assessment can be considered across all feeding questions.
UNICEF UK & National Infant Feeding Network	12	Third point on the table page 12 – Are there any interventions that promote attachment/bonding in the postpartum period?	Evidence suggests that infant feeding has a profound impact on the mother-infant relationship and that this has an impact on the short and long term health and wellbeing outcomes of the mother and child. We agree that this should be linked back to the NICE guidance on antenatal and postnatal mental health. However, an additional question should be developed in relation to infant feeding and building close and loving relationships for the mother and baby Unicef, 2012, The Evidence and rationale for the Unicef UK Baby Friendly imitative Standards. Unicef 2017Early Moments Matter: for every child Additional review question: What information and support should be provided to mothers on the association between infant feeding and relationship building?	Thank you for your comment. It is likely that the committee will agree with you on this point, and therefore will want to prioritise the relationship impact of feeding as an outcome in feeding reviews, but we cannot pre-empt deliberations of the committee. If the committee do prioritise this as an outcome, we do not think there is additional value in asking a separate question on providing information, as recommendations can be made on this in the context

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				of the existing breastfeeding reviews.
UNICEF UK & National Infant Feeding Network	13	Seventh point on the table – what is the risk of co-sleeping in relations to sudden infant death syndrome	Evidence suggests that separation of the mother and baby impacts on both successful breastfeeding and building close and loving relationships. Variation in practice is huge – we strongly recommended that this question is updated. www.isisonline.org.uk Unicef UK Baby Friendly Initiate, ISIS, The Lullaby Trust, 2017, Co-sleeping and SIDS: A guide for health professionals Update review question: What information and support should be provided to mothers on where their baby should sleep?	Thank you for your comment. In response to numerous stakeholder comments we realised that we had underestimated the importance of sleeping to stakeholders (and especially the risk of death and risk of poor attachment if advice is not of high and consistent quality). We will therefore add two questions on the topic of infant sleeping; "What are the risk factors in relation to infant sleeping practices for sudden infant death syndrome (SIDS)?" and "What interventions are effective in preventing sleep difficulties?"

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UNICEF UK & National Infant Feeding Network	18	27, 28	Taking into account comment 7 above: 3.2 could read What information should be given to parents on routine care of babies, including where their baby should sleep?	Thank you for your comment. We agree with the change, but for process reason we will separate the question into a separate review on "What interventions are effective in preventing sleep difficulties?"
UNICEF UK & National Infant Feeding Network	19	18	Main outcomes Maternal outcomes – 6 emotional attachment and Baby outcomes: 12 social and emotional development These need to be included in the key issues and questions section if they are to be listed as outcomes. Suggest: Page 18 line 12 to read 2 Identifying and assessing the health and wellbeing needs in women Page 18 line 24 to read Identifying and assessing the health and wellbeing needs in babies Page 18 line 27/28 to read 3.2 What information should be given to parents on routine care of babies, including where their baby should sleep? Page 18-19 add to section 4 Planning and management of babies feeding	Thank you for your comment. NICE processes allow for several 'outcomes' to be attached to one 'key issue and question', but not the other way around. Therefore the suggested change would underemphasise the importance of the outcomes you highlight, which we believe would not be acceptable to stakeholders. We have added the

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			4.6 What tools for clinical review of breastfeeding are effective during the first 8 weeks after birth 4.7 What information and support should be provided to mothers on the association between infant feeding and relationship building?	proposed question on sleeping as this is not covered by an outcome, but not the proposed question on breastfeeding assessment and relationship building as these are covered by outcomes as described above.
UNICEF UK & National Infant Feeding Network	General	General	Change all instances of "breast feeding" to "breastfeeding" for consistency	Thank you for your comment pointing out inconsistencies in wording. For the new guideline we have made this wording consistent.
University Hospitals of Morecambe Bay NHS Trust	General	general	MEOWS chart not designed / relevant for use in community as intermittent use of same not accurate diagnostic tool.	Thank you for your comment. Although the MEOWS chart was only supposed to be an example, we have removed the reference to avoid confusion.

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University Hospitals of Morecambe Bay NHS Trust	General	General	Currently, Trusts have insufficient midwives to deliver safe & effective care across Units & Community. Ageing demographic, retention issues (especially stress- related) plus reduced recruitment compounded by withdrawal of Bursary, suggests numbers will significantly decrease further. With this in mind - who is going to deliver extended P/N care ?	Thank you for your comment. While we cannot pre-empt recommendations written by the committee, NICE guidelines are always written in consideration of health economic issues such as you describe in your comments. Consequently if there is evidence that is not possible to deliver cost-effective care with midwives (for example because there are not enough midwives following the removal of the Bursary) then the recommendations will reflect this.
University of Southampton	1 1 2	20 26 13-15	The discussion of why the guideline is needed does not include a statement of the unique difficulties surrounding the provision of information about infant feeding. The postnatal period is an extremely vulnerable time for women. There is significant sociological evidence that new mothers feel	Thank you for your comment. In responding to each review question there is an opportunity to describe

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			guilt and shame surrounding their infant feeding decisions, however they end up feeding their babies. (See, for example, Thomson G, Eschbrich-Burton K, Flacking R. "Shame if you do, Shame if you don't: Women's experiences of infant feeding." *Maternal and Child Nutrition* 11(1), (2015)) Such feelings of guilt and shame, occurring at a particularly vulnerable time, can have significant detrimental effects on the well being of new mothers. Many mothers feel as if they are required to justify decisions to use formula and must have a 'good enough excuse' to avoid being seen as bad mothers. Fiona Woollard has connected this to illegitimate assumptions that there is a defeasible duty to breastfeed. (See Woollard, Fiona, Porter, Lindsey, "Breastfeeding and Defeasible Duties to Benefit", Journal of Medical Ethics, Published Online First: 10 February 2017. doi: 10.1136/medethics-2016-103833.) There is also evidence that guilt and shame surrounding formula feeding may lead new mothers to conceal their feeding practices from midwives and other health professionals, which may put their babies' health at risk. (See Lee, E., & Furedi, F. (2005). Mothers' experience of, and attitudes to, using infant formula in the early months. *School of Social Policy, Sociology and Social Research, University of Kent*, 1-93.) These feeling persist despite the good intentions of many health workers. At the same time, infant feeding is a major public health issue. A recent American study estimates that 3,340 excess deaths annually are due to suboptimal breastfeeding rates (Bartick, M. C., Schwarz, E. B., Green, B. D., Jegier, B. J., Reinhold, A. G., Colaizy, T. T., Bogen, D. L., Schaefer, A.	why a particular question is needed, and we think this might be a more suitable location to include your suggested paragraph. We will therefore include a discussion of the importance of minimising shame and guilt here.

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			J., and Stuebe, A. M. (2016) Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs. Maternal & Child Nutrition, doi: 10.1111/mcn.12366.) The UK has some of the lowest breastfeeding rates in the world and extremely high breastfeeding disappointment rate. (McAndrew F, Thompson J, Fellows L, Large A, Speed M and Renfrew M (2012). Infant Feeding Survey 2010. London: The NHS Information Centre.) Patient testimony also shows that women perceive staff as being "forbidden" from offering guidance on formula with one patient reporting that she was told to "google" the different brands (Personal correspondence to Woollard). There is an urgent need for guidance to help health practitioners protect the fragile choice to breastfeed, while reducing guilt, shame and judgment surrounding decisions to use formula. We suggest that the following is added to the outline of why the guideline is needed: "Healthcare workers face unique difficulties in providing information about infant feeding due to the significance of breastfeeding for infant and maternal health and the potential for detrimental effects on vulnerable women and neonates of shame and guilt surrounding infant feeding decisions."	

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